

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11015

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Dauphin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>				c. LENGTH OF STAY IN 1b <u>Minutes</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 111 1 Mi. South of Parkton</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>ABRAMS</u> Last <u></u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1909</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jacob Levi</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Block</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT <u>911 N. Second St., R. J. Reese Harrisburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BURNED TO DEATH</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/24 1961</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 111</u> 20f. (City or town) <u>BALTO</u> (County) <u>MD.</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>G. M. France</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept 27, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Paxtang, Penna.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kortenstien, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

(M)

(I)

11523

Name of Deceased		Age		Sex		Race	
Date of Death		Time of Death		Place of Death		Cause of Death	
Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report		Cause of Report	
Manner of Report		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Final Report		Time of Final Report		Place of Final Report		Cause of Final Report	
Manner of Final Report		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9865

CERTIFICATE OF DEATH

Reg. Dist. No.

09854

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCK RAVEN		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1639 Cottage Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Klementyna Middle Adamska Last K		4. DATE OF DEATH Month Sept Day 3 Year 1961	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 23 - 1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT Home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA Poland	
13. FATHER'S NAME JOZEF OLSZEWSKI		14. MOTHER'S MAIDEN NAME ANNA PAJENSKA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DR BRUNO ADAMSKI		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Arteriosclerotic Cardiovascular renal disease. DUE TO (b) Septamyeloma. DUE TO (c) 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar , 1961, to Sept 3 , 1961, that I last saw the deceased alive on Sept 3 , 1961, and that death occurred at 9:15 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold H Burns M.D.		ADDRESS (Street, city or town, state) 8106 Hayford Rd. DATE SIGNED 9-6-61	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sept 7, 1961	22c. NAME OF CEMETERY OR CREMATORY DOLAN VALLY	22d. LOCATION (City, town, or county) (State) BALTIMORE Co Md
23. FUNERAL DIRECTOR'S SIGNATURE CHAS F EVANS & SON		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	24a. REC'D BY REGISTRAR DATE SEP 7 '61

(M)

(1)

2282

STATE OF SOUTH

2282

Chas. E. ...
...
...

9866

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. Inst. name and address) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 PLAYFIELD Rd		d. STREET ADDRESS 13 PLAYFIELD Rd	
3. NAME OF DECEASED (Type or print) LAURA JULIA ANGEL		4. DATE OF DEATH Month 9 Day 9 Year 1961	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1890
9. AGE (In years last birthday) 71 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GOTTLIEB KILCHENMAN		14. MOTHER'S MAIDEN NAME ELIZABETH KREBS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-3145B	
17. INFORMANT LUTHER C. ANGEL		Address AS #2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-5-59 19 59 , to 9-5-61 19 61 , that I lost the deceased alive on 9-5-61 19 61 , and that death occurred at 6 PM M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Jack E Collins M.D. 2 Keir Lp		9-11-61	
PHYSICIAN'S NAME (Type) JACK E Collins		Balt 22	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/12/61	22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE	22d. LOCATION (City, town, or county) (State) DORSEY, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Andrew Bradley, Dundalk, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '61	
24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3888

M

1. Name of deceased: John Doe

2. Sex: Male

3. Race: White

4. Date of birth: 12/15/1925

5. Place of birth: New York, N.Y.

6. Date of death: 10/10/1995

7. Place of death: Home

8. Cause of death: Heart Disease

9. Manner of death: Natural

10. Signature of physician: [Signature]

11. Signature of registrar: [Signature]

12. Date of registration: 10/15/1995

13. Registrar's name: John Doe

14. Registrar's address: 123 Main St, New York, N.Y.

15. Registrar's phone: 123-4567

16. Registrar's fax: 123-4567

17. Registrar's email: john.doe@ny.gov

18. Registrar's title: Registrar

19. Registrar's department: Health Department

20. Registrar's office: City Hall

21. Registrar's district: 1

22. Registrar's precinct: 1

23. Registrar's ward: 1

24. Registrar's block: 1

25. Registrar's lot: 1

26. Registrar's lot number: 1

27. Registrar's lot number: 1

28. Registrar's lot number: 1

29. Registrar's lot number: 1

30. Registrar's lot number: 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

19856

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Dauphin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>		c. LENGTH OF STAY IN 1b <u>Minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRISBURG</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 111 1 Mi. South of Parkton</u>				d. STREET ADDRESS <u>2715 N. 4th St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lewis M. ARONSON</u>				4. DATE OF DEATH Month Day Year <u>Sept. 24 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1902</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Distributor</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Julius Aronson</u>				14. MOTHER'S MAIDEN NAME <u>Helen Mihls</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>171 28 1443</u>		17. INFORMANT <u>Richard J. Reese</u> 911 N. Second St., Harrisburg, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burned to death</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>9/24 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 111</u>		20f. (City or town) (County) (State) <u>Balto. Ind</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 27, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Paxtang, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEATH CERTIFICATE

1058

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11026

Reg. Dist. No. 09857

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) d. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u>	
c. LENGTH OF STAY IN 1b <u>Minutes</u>		d. STREET ADDRESS <u>2715 N. 4th St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 111 1 Mi. South of Parkton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>ATKINSON</u> Last <u>ATKINSON</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1904</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Levi</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Block</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>199 34 8378</u>	
17. INFORMANT <u>R. J. Reese</u>		18. ADDRESS OF INFORMANT <u>911 N. Second St., Harrisburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Burned to death</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>9/24 1961</u> Hour <u>4</u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 111</u>	
20f. (City or town) <u>DAUPHIN</u>		20g. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>9/24/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Paxtang, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>SEP 26 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1911

1911

Blank form with horizontal lines for text entry.

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9867

Item 2 Film 6-22 9/16/61 JWK

09858

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>31 days</u>		d. STREET ADDRESS <u>355 Maryland Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HATTIE</u>		4. DATE OF DEATH <u>9 9 1961</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 28 1880</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>GEORGE STREAKER</u>		14. MOTHER'S MAIDEN NAME <u>ALICE MAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Records Spring Grove State Hospital</u>	
17. INFORMANT <u>Records Spring Grove State Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.01</u> DUE TO <u>Myocardial insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u>			
(c) <u>Female changes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>in wheel chair for 3 yrs</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/14/61</u> to <u>9/9/61</u> , that (I) (we) last saw the deceased alive on <u>9/9/61</u> , and that death occurred at <u>9:05 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bruno Radauskas</u> M.D.		22b. DATE SIGNED <u>9/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		22d. ADDRESS <u>Spring Grove St Hosp. Catonsville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Friedman Schwalb</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>	
ADDRESS <u>3512 Frederick Ave. (29)</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

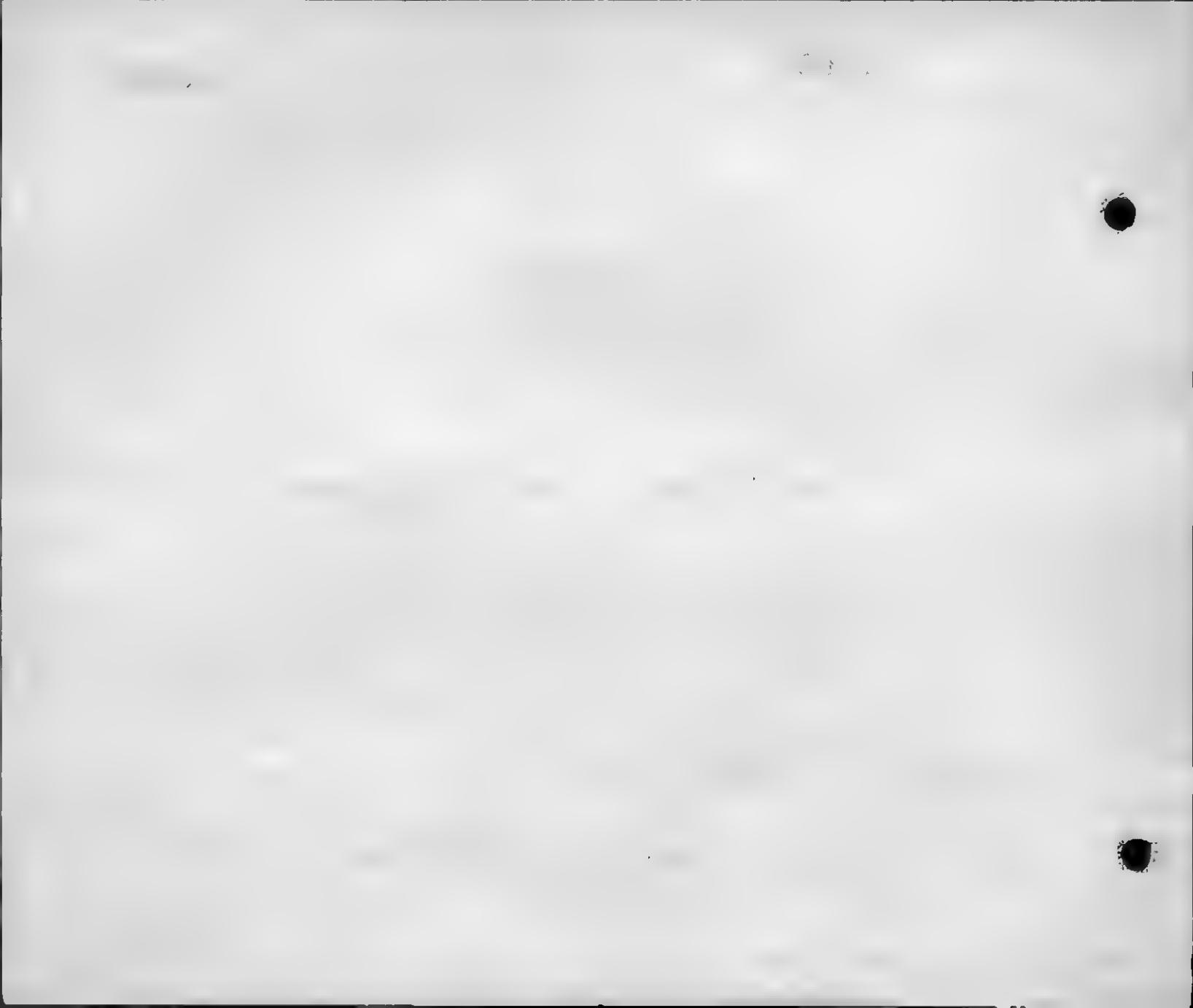
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9868

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09859

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AR BUTUS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AR BUTUS</u>		d. STREET ADDRESS <u>4216 KENSINGTON RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4216 KENSINGTON RD.</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD ROLAND AUER</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 17, 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, avoid if retired) <u>Record Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. AUER</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wells</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W.I.</u>	
17. INFORMANT <u>W. L. AUER - 4 Willow Hill Rd.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 29, 1961</u> to <u>Sept. 1, 1961</u> , that (I) (not) last saw the deceased alive on <u>Aug. 19, 1961</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John F. Schaefer</u>		22b. DATE SIGNED <u>9-3-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER</u>		22d. ADDRESS <u>401 Randon Rd. Balto. 29 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-5-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Forley - Cavanaugh F.H. - Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 '61</u>	
ADDRESS <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

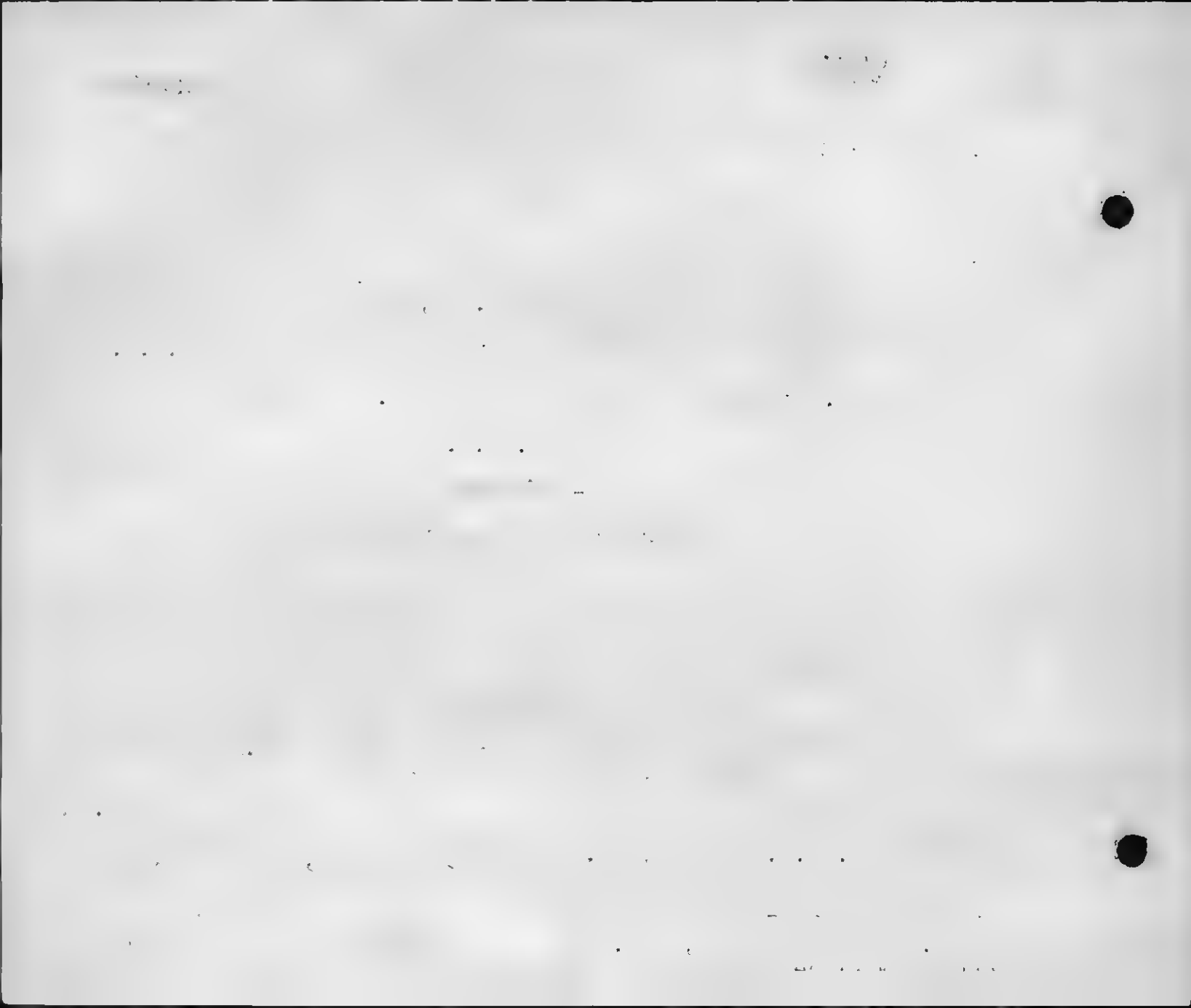
VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
9869														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Presbyterian Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) a. STATE <u>Maryland</u> b. COUNTY <u>Hagerstown</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>2133</u>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily Baechtel</u>					4. DATE OF DEATH Month Day Year <u>September 12 1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26, 1970</u>		9. AGE (In years last birthday) <u>90</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
13. FATHER'S NAME <u>Charlee E. Baechtel</u>					14. MOTHER'S MAIDEN NAME <u>Sarah J. McDowell</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>Mrs. T.E. Elliott</u>					17. INFORMANT <u>Presbyterian Home</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Hypostatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>Arteriosclerotic cardiovascular disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>42</u>										INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> years				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (the doctor) attended the deceased from <u>January 1959</u> to <u>Sept. 12, 1961</u> , that (I) (we) last saw the deceased alive on <u>September 6, 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>A. D. M.D.</u>					22b. DATE <u>Sept. 15, 1961</u>									
22c. PHYSICIAN'S NAME (Type) <u>Dr. S.J. Venable, Jr.</u>					22d. ADDRESS <u>7215 York Road, Baltimore 12, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>9-15-61</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>					23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc.</u>					25a. REC'D BY REGISTRAR <u>SEP 18 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					25c. DATE <u>SEP 18 '61</u>									

1900 Eutaw Place



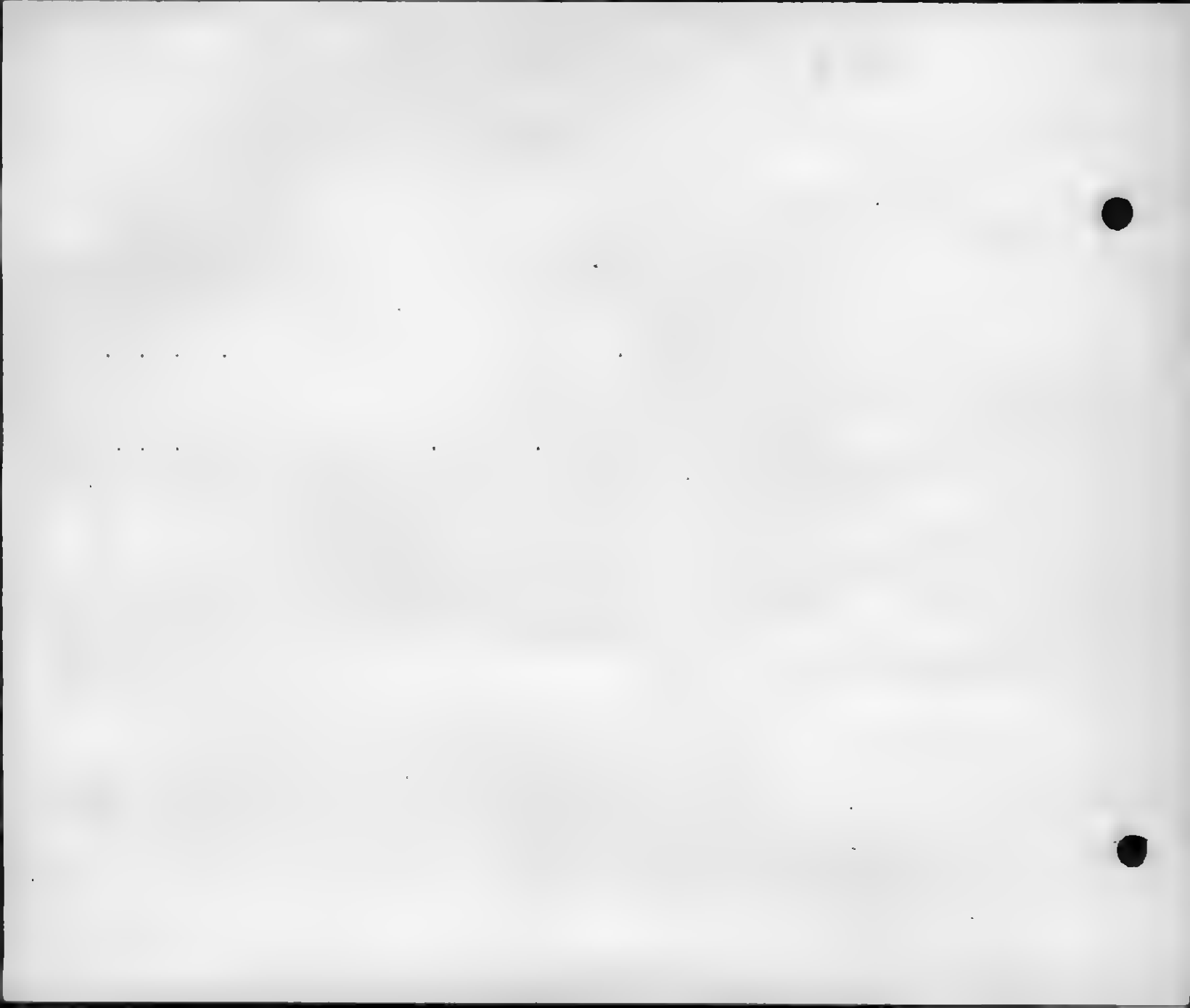
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9870 CERTIFICATE OF DEATH 09861

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 Third Avenue				d. STREET ADDRESS 214 Third Avenue			
3. NAME OF DECEASED (Type or print) First James Middle H. Last Barker				4. DATE OF DEATH Month September Day 13 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1880		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Edelen Co.		11. BIRTHPLACE (State or foreign country) Anne Arundle, County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Barker				14. MOTHER'S MAIDEN NAME Eletha ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. James M. Barker-412 Fifth Ave. S.E. Glen Burnie			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Old age (83) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 15, 1961 to Sept. 13, 1961 that (I) (we) last saw the deceased alive on Sept. 13, 1961 , and that death occurred at 12M , from the causes and on the date stated above.							
22a. SIGNATURE Henry Armanas		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Sept. 13, 1961			
22c. PHYSICIAN'S NAME (Type) HENRY ARMANAS		22d. ADDRESS 1934 Wilkens Hve. Balto. Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9-16-61	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jackson & Sons North + Pennsylvania-Balton Md.				25a. REC'D BY REGISTRAR DATE SEP 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

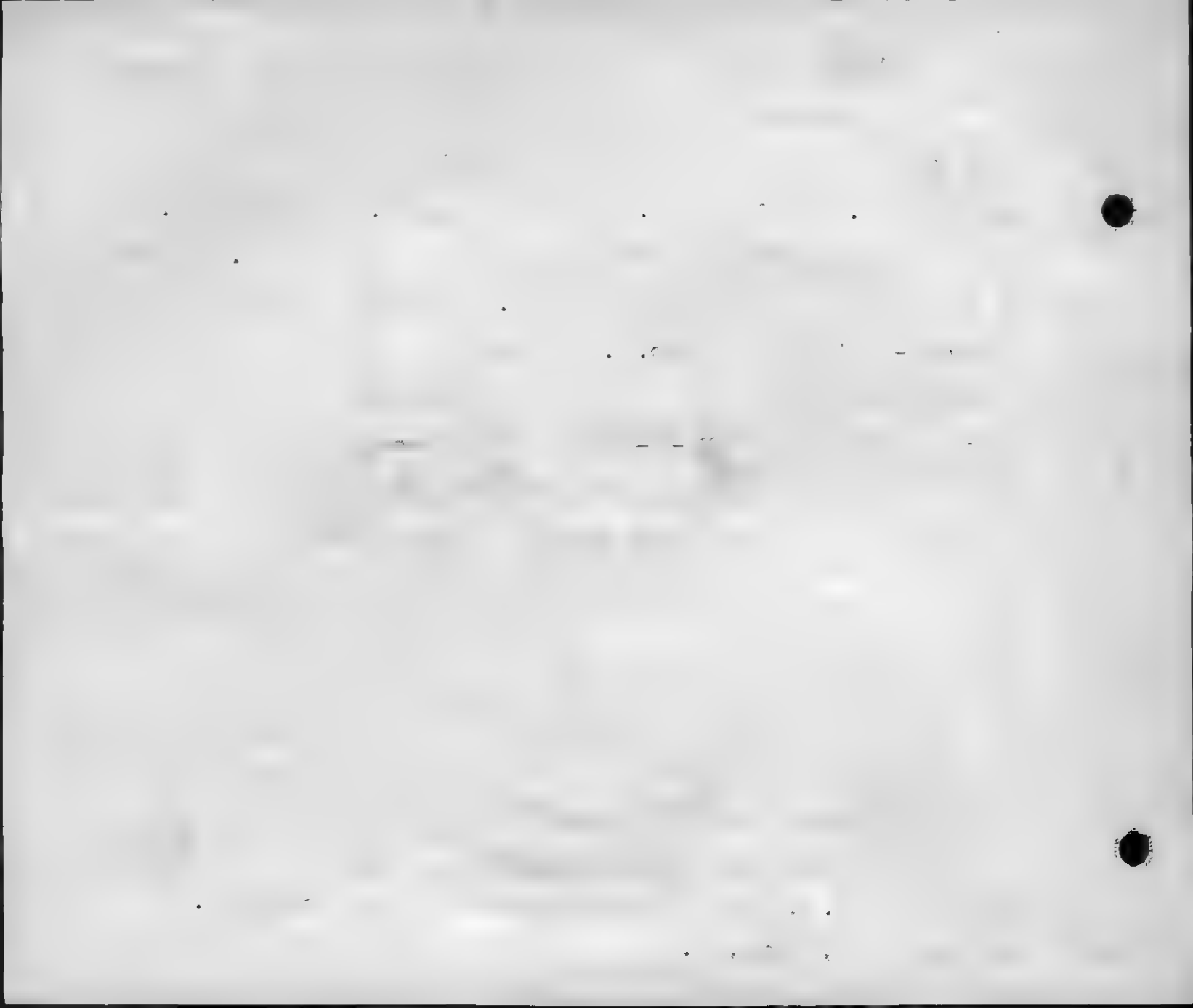
9871 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09862

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Phoenix c. LENGTH OF STAY N in d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paper Mill Rd. near Old York Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix d. STREET ADDRESS Paper Mill Rd. near Old York Rd.	
3. NAME OF DECEASED (Type or print) BURNIE EUGENE BARNETT 4. SEX Male 5. COLOR OR RACE White 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer- retired 8. FATHER'S NAME George Barrett		9. DATE OF DEATH Sept. 27, 1961 10. AGE (In years last birthday) 74 yrs 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA 13. MOTHER'S MAIDEN NAME Martha Martin 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I 15. SOCIAL SECURITY NO. 214-03-0226 16. INFORMANT Family Records 17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion (b) Diabetes Mellitus (c) 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles F. O'Donnell M.D. EXAMINER'S NAME (Type) Charles F. O'Donnell Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Oct. 1, 1961 22c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery 22d. LOCATION (City, town, or country) (State) Cockeysville, Md.			
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Md. ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 5 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

VS. AT5ME
SM 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9872

CERTIFICATE OF DEATH

Reg. Dist. No. 3

09863

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Shelby</u> Last <u>Basford</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.	10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>breakman B.O</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George BASFORD</u>				14. MOTHER'S MAIDEN NAME <u>Laura ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Mahelle Smith</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> +2.5.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u> </u> Year <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>18 Sept., 1961</u> , to <u>28 Sept., 1961</u> , that I last saw the deceased alive on <u>27 Sept., 1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				ADDRESS (Street, city or town, state) <u>2501 York Rd #4 Md</u>			
DATE SIGNED <u>9/28/61</u>							
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Garage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garage Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Dandelion</u>				ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>							





FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09865

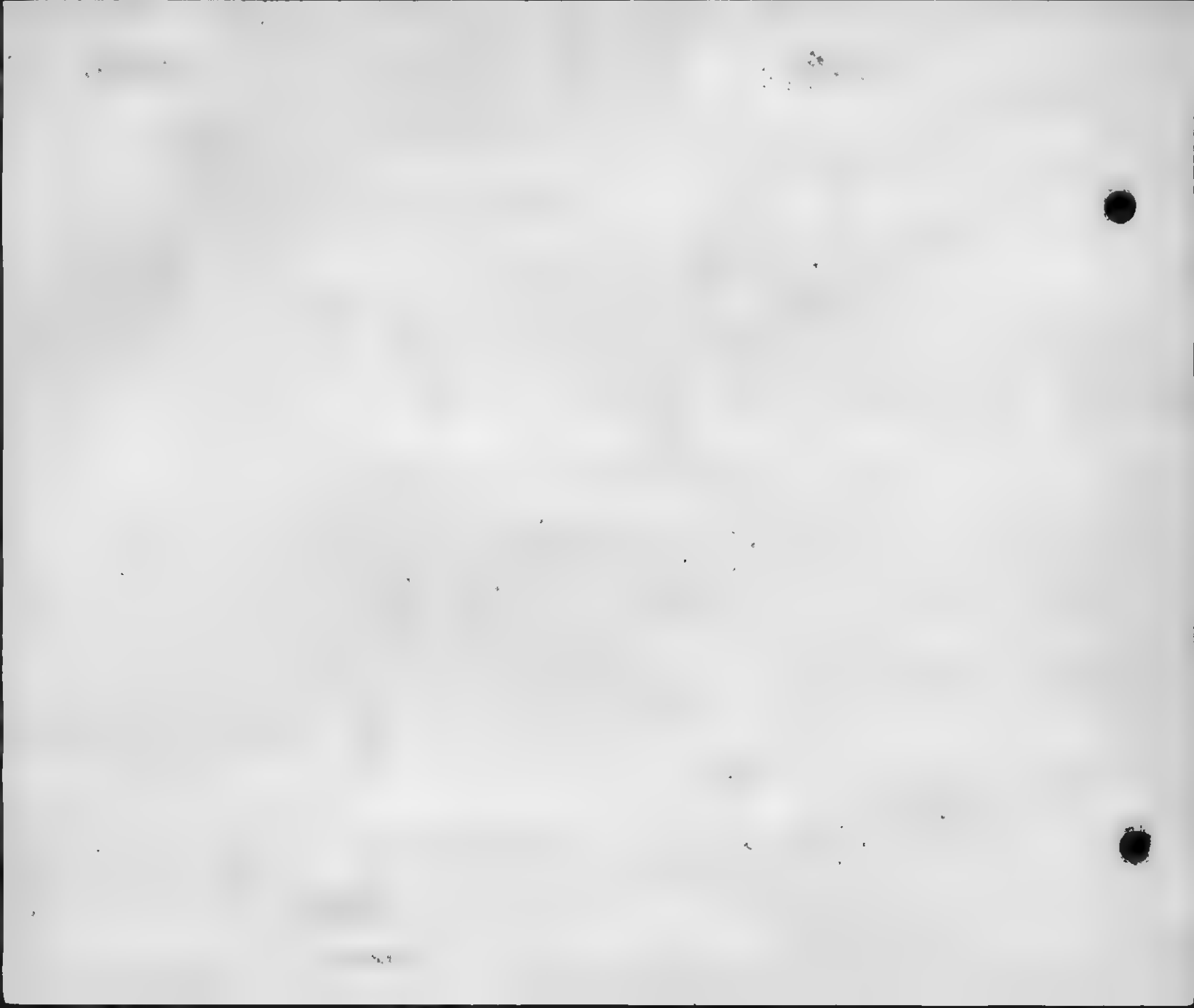
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Reimburse (for no reimbursement)) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 6417 Colesville Road - Hyattsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 6417 Colesville Road	
3. NAME OF DECEASED (Type or print) Anna		4. DATE OF DEATH Month September Day 21 Year 1961	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Huber		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 904-5 DUE TO Acute Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Bronchial Pneumonia caused			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Interval between onset and death			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 9-13-61 pt. slipped to floor sustaining a comminuted frac. of the neck of left femur	
20c. TIME OF INJURY Month, Day, Year 9-13 1961 Hour, a.m. 7:05		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville 28, Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. M. Kieffer		DATE SIGNED 9-21-61	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 25, 1961	
22c. NAME OF CEMETERY OR PLACE OF BURIAL George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md	
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md		24a. REC'D BY REGISTRAR SEP 25 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kneave	



1
M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if the deceased may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9875
CERTIFICATE OF DEATH
09866

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1112708 Southern Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Angelswing Home</u>		d. STREET ADDRESS <u>6811 Campbell Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Blanche Florida Bayless</u>		4. DATE OF DEATH Month Day Year <u>Sept 26 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27 1876</u>
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELECTRIC</u>	9. AGE (In years, if under 1 year, if under 24 hrs.) last birthday Months Days Hours Min. <u>84 yrs.</u>
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman M. Bayless</u>		14. MOTHER'S MAIDEN NAME <u>Annie Clarke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO., 17. INFORMANT <u>None</u> <u>T. W. Katerkamp</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>(1) - Broncho-Pneumonia</u> DUE TO (b) <u>(2) - Cerebral Hemorrhage</u> DUE TO (c) <u>(3) - Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 24 1961</u> to <u>Sept 26 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 24 1961</u> , and that death occurred at <u>11:11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Earl L. Chambers</u>		22b. DATE SIGNED <u>Sept 26 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers - M.D.</u>		22d. ADDRESS <u>4108 Liberty Rd Baltimore - Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT Cem</u>	23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. RUCK</u>		25a. REC'D BY REGISTRAR <u>SEP 29 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>C. Shum & Hand</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

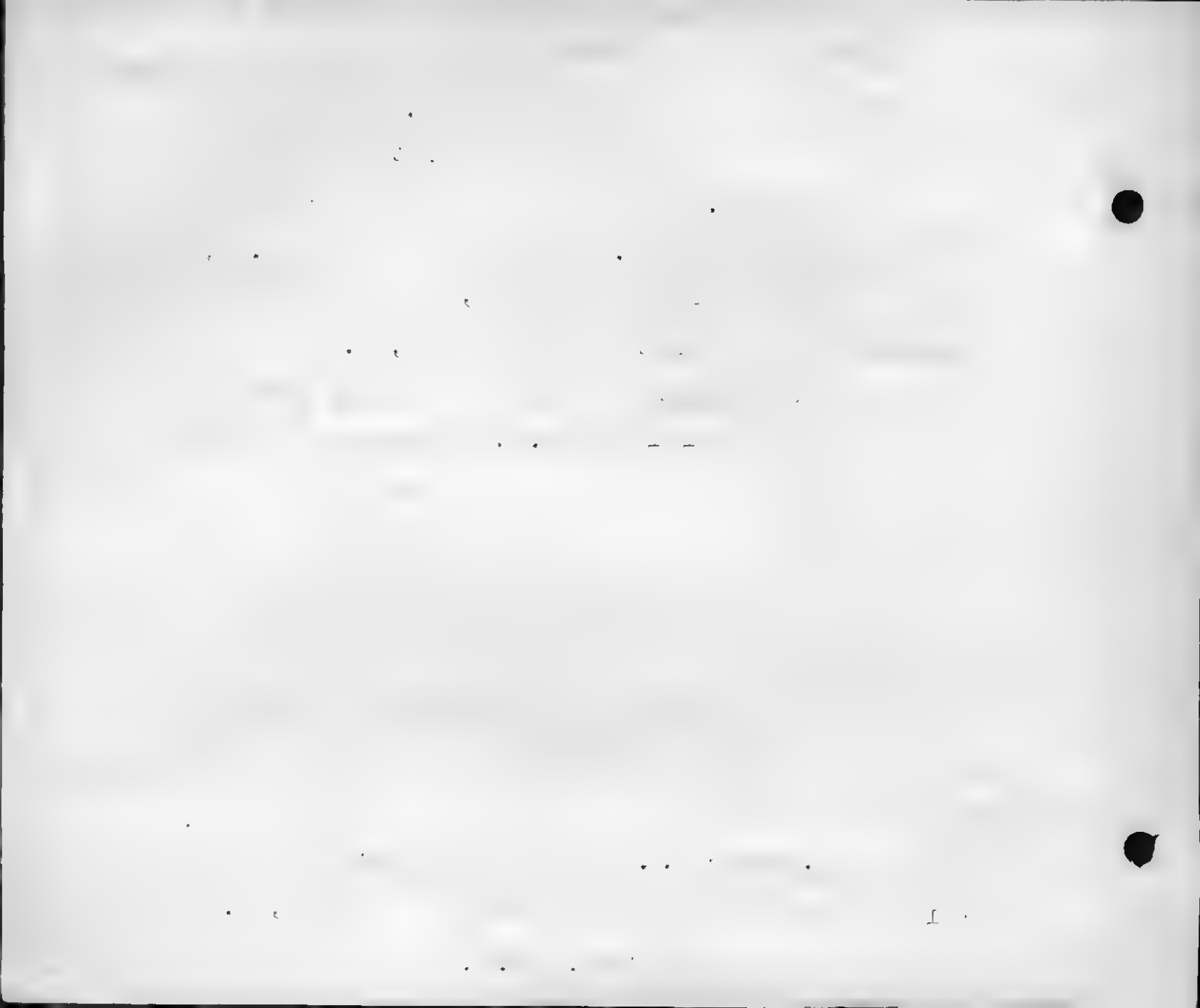
9876

CERTIFICATE OF DEATH

Reg. Dist. No. 09867

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6900 Beech Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Katherine Middle C. Last Beitman		4. DATE OF DEATH Month Sept. Day 25, Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1893
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME John Courtney		14. MOTHER'S MAIDEN NAME Catherine Broderick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 705-05-6732	
17. INFORMANT Mrs. C. Melissa Marcin, 4156 Pimlico Road		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-18 , 19 61 , to 9-25 , 19 61 , that I last saw the deceased alive on 9-23 , 19 61 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul G. Mueller		ADDRESS (Street, city or town, state) 6411 Belair Rd. Balt (6) Md	
PHYSICIAN'S NAME (Type) Paul G. Mueller, M.D.		DATE SIGNED 9/25/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/61	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Vernon J. ...		24a. REC'D BY REGISTRAR SEP 26 '61	
ADDRESS 611 Park Heights, Balto. Md.		24b. REGISTRAR'S SIGNATURE Arthur L. ...	

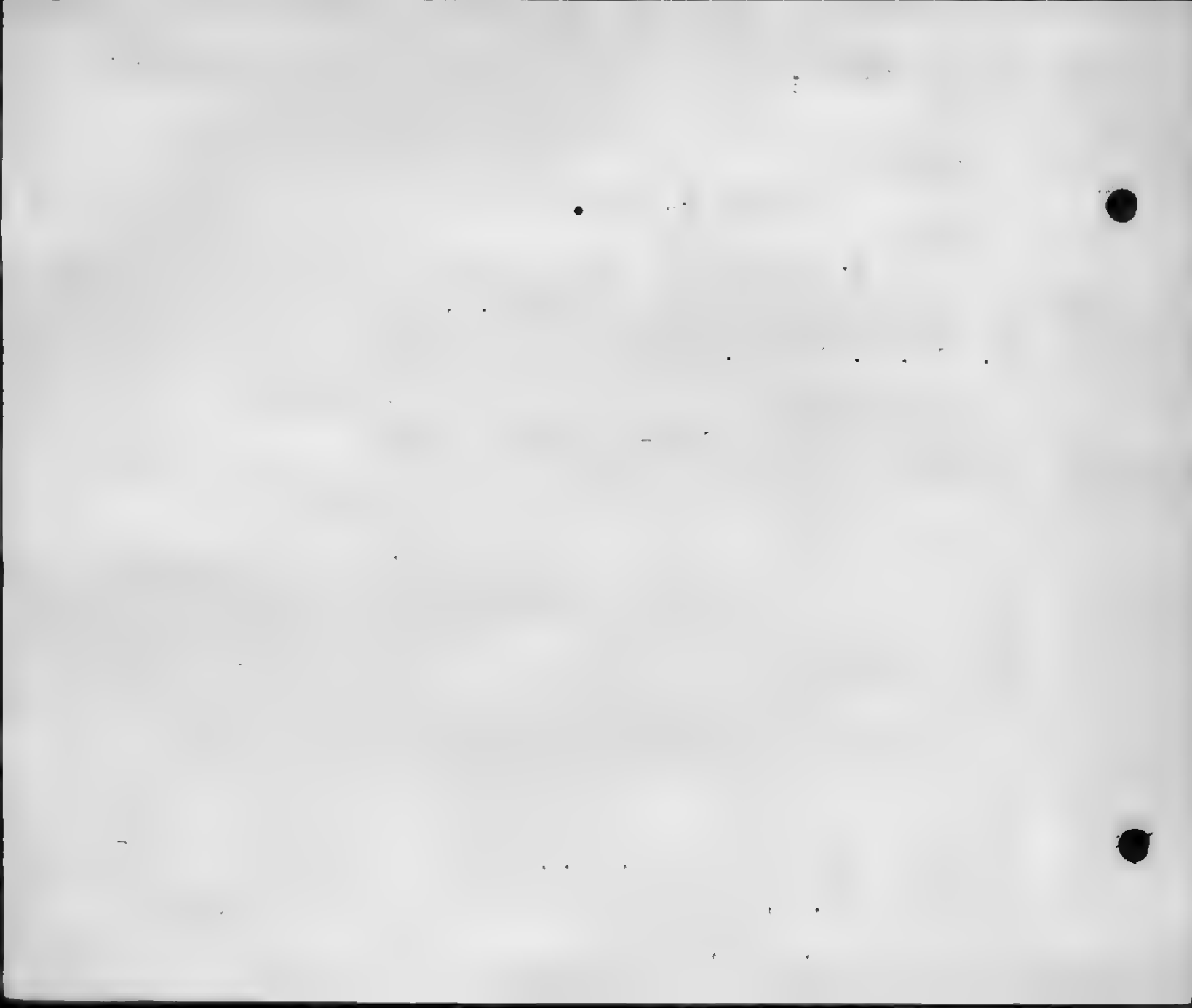
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS. AISME
5M 9/60

DATE _____

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9878

09869

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosewood State Training School</u> c. LENGTH OF STAY IN 1b <u>Cochran Mills</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Isaiah</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Isaiah</u> d. STREET ADDRESS <u>5013 Church St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Jeffrey</u> First <u>Berg</u> Middle <u>Berg</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-3-57</u>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Myron Berg</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Pearl Berg</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Hospital Records</u> Address <u>Isaiah</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>5711</u> IMMEDIATE CAUSE (a) <u>Severe Enterocolitis</u> DUE TO <u>Dehydration</u> (b) <u>Dehydration</u> DUE TO <u>Dehydration</u> (c) <u>Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Encephalitis with severe mental deficiency</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> 1960 to <u>4-13</u> 1961 , that (I) (we) last saw the deceased alive on <u>9-13</u> 1961 , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Harry G. Butler</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9-14-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Isaiah</u>		23d. LOCATION (City, town, or county) (State) <u>Isaiah</u> <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack L. Lavin</u>						ADDRESS <u>2100 E. Lake St.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 15 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert L. Lavin</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9879

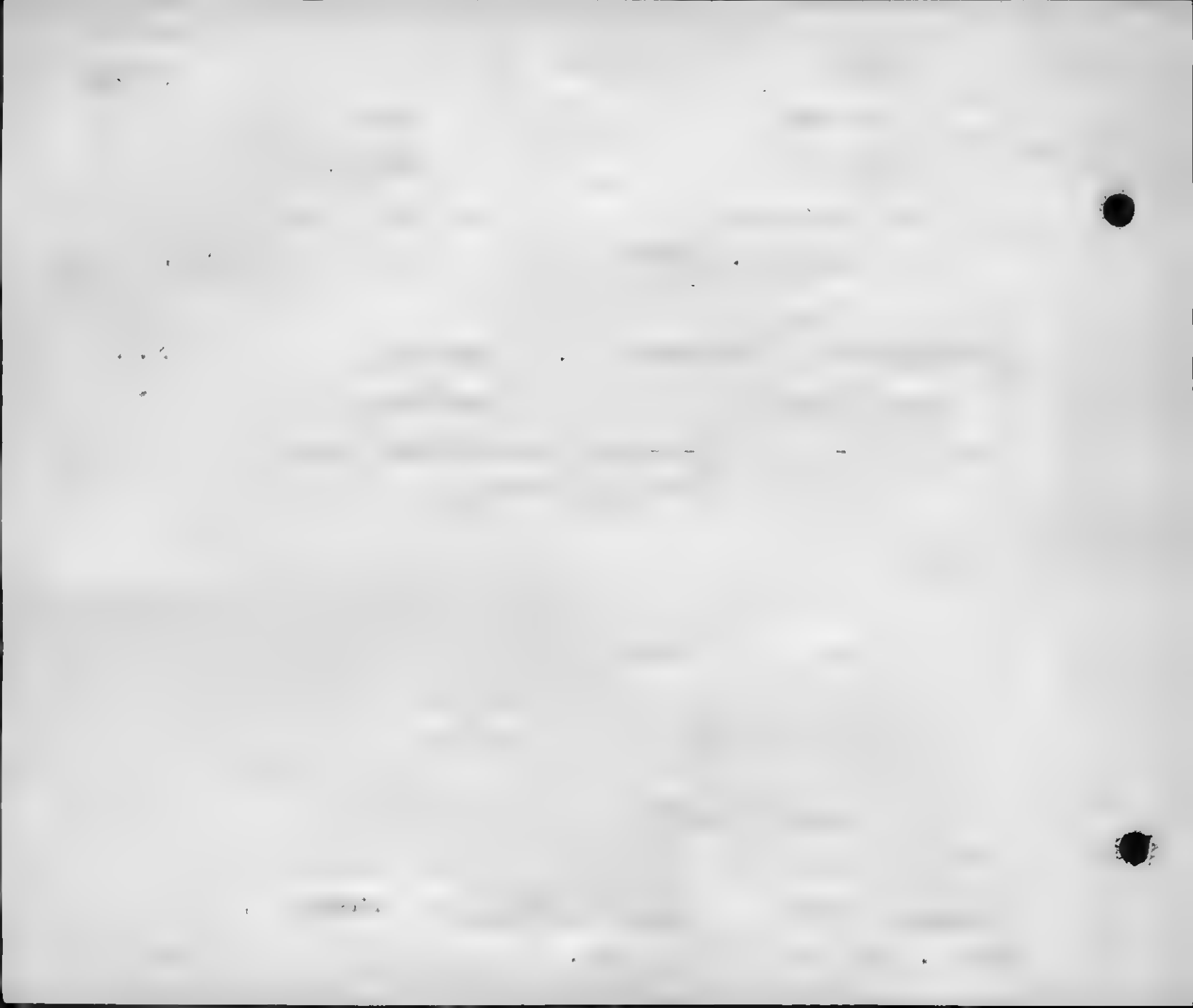
09870

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Essex (21) c. LENGTH OF STAY IN b Essex (21) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2223 Corcoran Road				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21) d. STREET ADDRESS 2223 Corcoran Road			
3. NAME OF DECEASED (Type or print) ALFRED E. BLACKMORE				4. DATE OF DEATH September 24, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1901	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oxygen Operator		10b. KIND OF BUSINESS OR INDUSTRY Gas Bottling Co.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chauncey Blackmore				14. MOTHER'S MAIDEN NAME Edna Watson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 134-09-0626		17. INFORMANT Marie Blackmore Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion 12011 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 min						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 9-25-61							
ACTUAL SIGNATURE SAUL C. Collins		EXAMINER'S NAME (Type) SAUL C. Collins		DATE SIGNED 9-25-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/25/61		22c. NAME OF CEMETERY OR CREMATORY Schalderer Funeral Home Spring Forest Cemetery		22d. LOCATION (City, town, or country) (State) Binghamton, New York	
23. FUNERAL DIRECTOR James E. Bruzdinski 1407 Eastern Ave.				24a. REC'D BY REGISTRAR SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL EXAMINER

(M)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

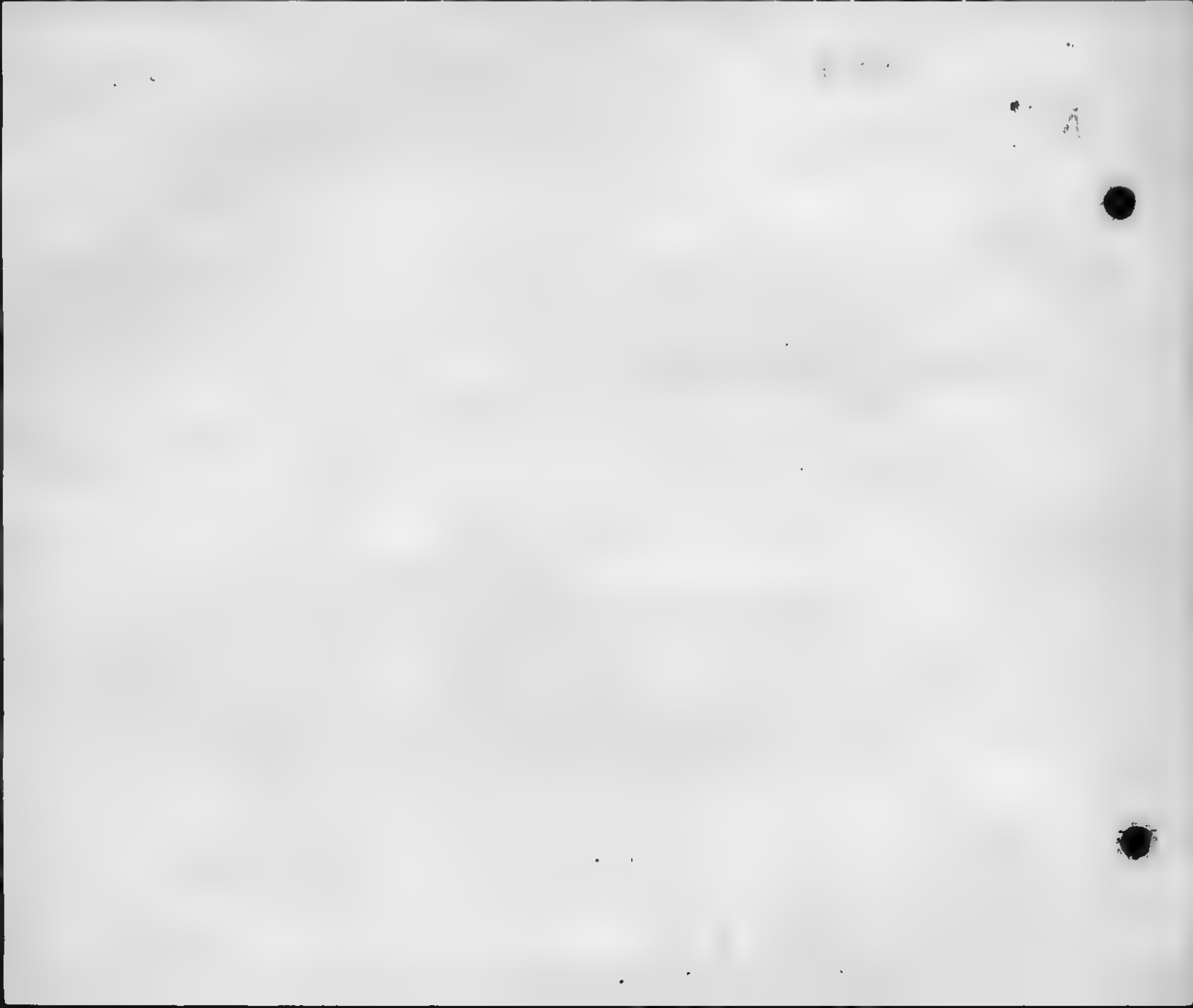
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9880

09871

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>1mth 13dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove St Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> d. STREET ADDRESS <u>575 Ontario St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Winfield Jackson Botts</u>		4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1961</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-1-74</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown ELECTRICIAN RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>WINFIELD GOLDSMITH</u> 14. MOTHER'S MAIDEN NAME <u>MALISSA GARDNER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u> 16. SOC. AL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Mrs. Josephine Ricketts</u> Address <u>Charlotte, N.C. 929 Scalp Bar Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> +42 X } DUE TO (b) <u>arteriosclerotic heart & kidney disease long standing</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-1-61</u> to <u>9-15-61</u> , that (I) (we) last saw the deceased alive on <u>9-14</u> 19 <u>61</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Stella Wachler</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <u>9-15-61</u>		22b. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 15, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GROVE CEM.</u>			
23d. LOCATION (City, town or county) <u>ABERDEEN</u> (State) <u>MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harre de Grace, Md.</u>					
25a. REC'D BY REGISTRAR <u> </u> DATE <u>SEP 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u> </u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

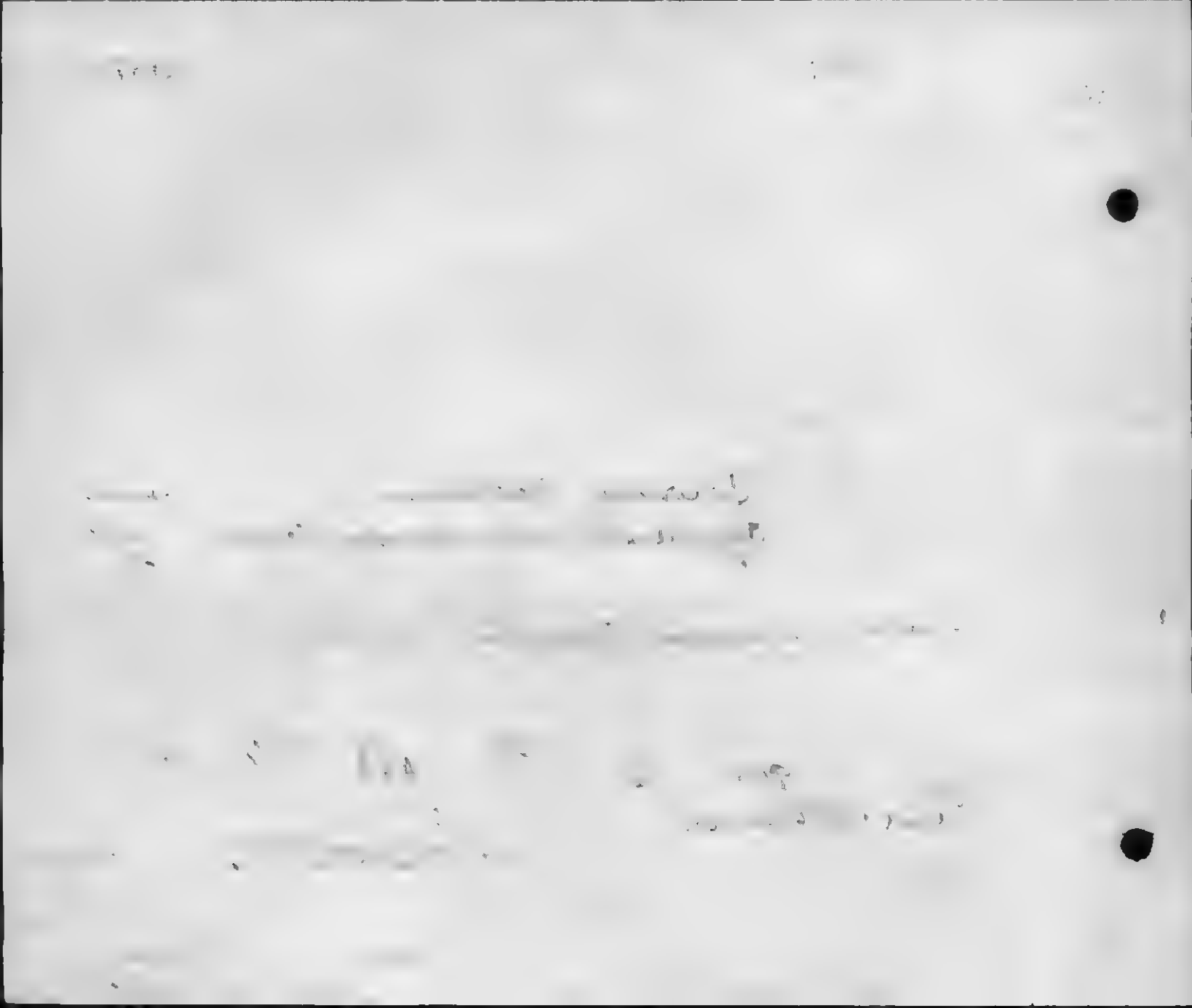
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9881

CERTIFICATE OF DEATH

09872

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>131 NEWBURG AVE</u>				e. STREET ADDRESS <u>131 NEWBURG AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES TERESIA BROOKS</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 17 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 1, 1888</u>	
9. AGE (in years last birthday) <u>72 yrs.</u>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JOSEPH GESSNER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SCHMITT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Raymond E. Brooks - 131 Newburg Ave.</u>			
17. INFORMANT <u>Raymond E. Brooks - 131 Newburg Ave.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Posterior Myocardial Infarction Feb. 1961</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/3</u> to <u>9/17</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>9/14</u> 19 <u>61</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles W. Johnson</u>				22b. DATE SIGNED <u>9/19/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles W. Johnson</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-21-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Cunningham T.H. - Catonsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 25 '61</u>			
ADDRESS <u>Catonsville, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Life pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09873

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b. 33 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Elkridge d. STREET ADDRESS 5415 Race Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MELVIN		First Middle Last A. BROOKS		4. DATE OF DEATH September 22 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH January 28, 1920		9. AGE (In years, if UNDER 1 YEAR, last birthday) 41 yrs. Months Days Hours M n.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Worker			
11. BIRTHPLACE (State or foreign country) Elkridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herman P. Brooks			
14. MOTHER'S MAIDEN NAME Mary MacIntosh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 217-03-5510			
17. INFORMANT Clinical Records		18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 491X DUE TO Brain for pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Subdural hematoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Sack & Collins		EXAMINER'S NAME (Type) Sack & Collins		DATE SIGNED 9-23-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			
22d. LOCATION (City, town, or country) (State) Baltimore Maryland		23. FUNERAL DIRECTOR Elroy O. Wilson Funeral Home		24a. REC'D BY REGISTRAR 1000 Brantley Ave.			
24b. REGISTRAR'S SIGNATURE SEP 27 '61		24c. DATE SEP 27 '61					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

9883

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

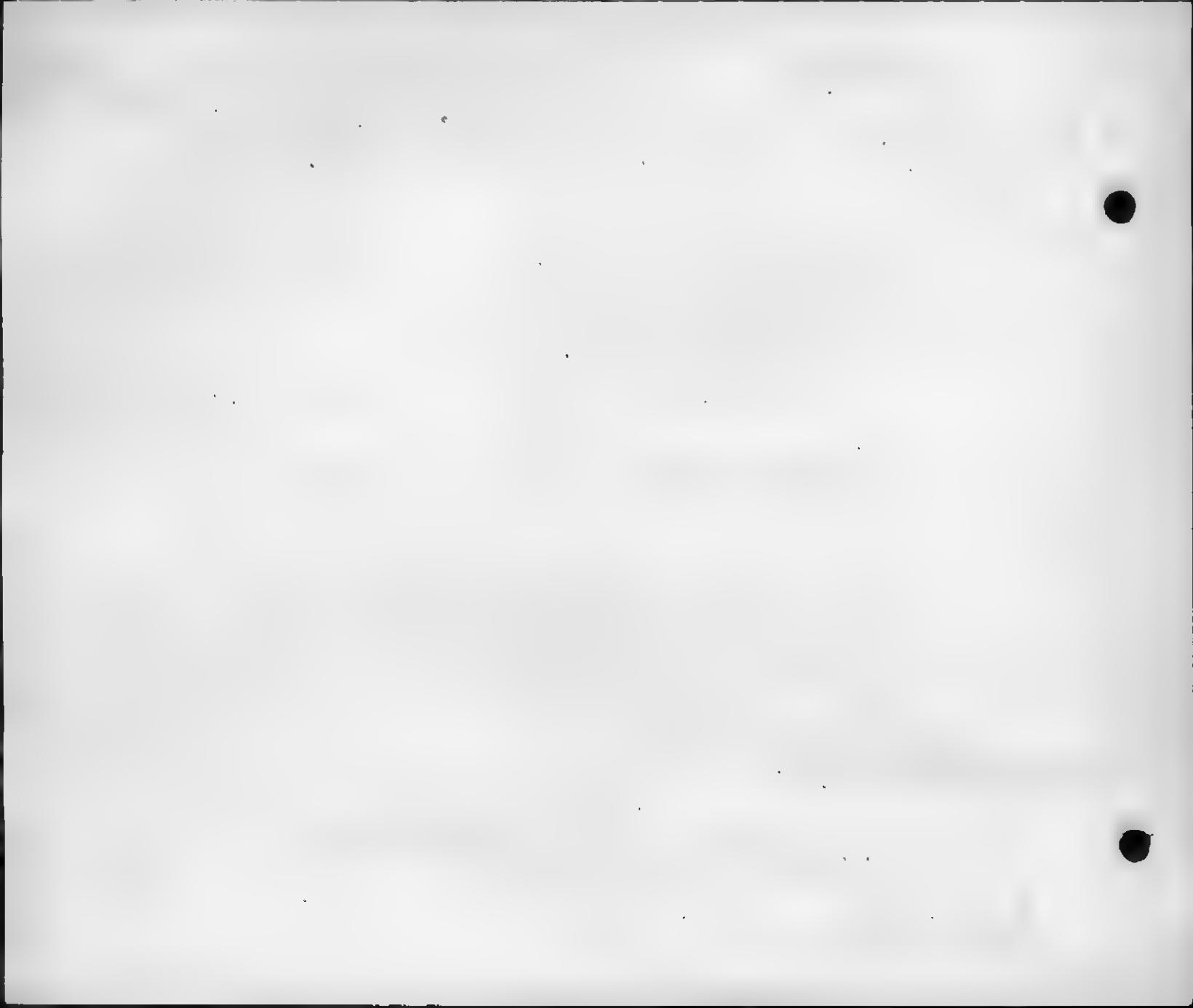
1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown Rural</i>		c. LENGTH OF STAY IN 1b <i>60 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>RUTH-ELMIRA-BROWN</i>		4. DATE OF DEATH <i>Sept 13 1961</i>	
5. SEX <i>FM</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 4-1881</i>
9. AGE (In years lost birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Henry Bailey</i>		14. MOTHER'S MAIDEN NAME <i>Emma Brothers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>710</i>	
17. INFORMANT <i>Mrs. Haver Brown-Reisterstown Ind</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of ascending colon</i> <i>153:0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <i>Hypertensive cardio-Vascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1961</i> to <i>Sept 13 1961</i> , that (I) met last saw the deceased alive on <i>9-12</i> <i>1961</i> , and that death occurred at <i>7:30a</i> M. from the causes and on the date stated above.			
22a. SIGNATURE <i>M.C. Porterfield</i>		22b. DATE <i>9/13/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>M.C. Porterfield</i>		22d. ADDRESS <i>Hampstead, Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-15-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>High-Grain</i>		23d. LOCATION (City, town, or county) (State) <i>Balto Ind Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tipton-ELMER, Hampstead Md</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 15 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>C. Edgar S. Kline</i>			

(M)

(I)

(C)

1



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9884

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09875

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, state of residence at time of admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
c. LENGTH OF STAY IN <u>14 YEARS</u>				d. STREET ADDRESS <u>408 OVERBROOK RD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>OVERBROOK ROAD</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u>		4. DATE OF DEATH <u>SEPT. 12 1961</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 12, 1909</u>		9. AGE (in years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN COPPINGER</u>		14. MOTHER'S MAIDEN NAME <u>BROGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05542</u>		17. INFORMANT <u>MR. Wm. J. BULLEN</u>		Address <u>408 OVERBROOK RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>		Address (Street, city, town, or county) <u>4905 YORK RD BALT 12, MD.</u>		DATE SIGNED <u>9/13/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 15, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR <u>HENRY W JENKINS & SONS</u>		ADDRESS <u>4905 YORK RD BALT 12, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

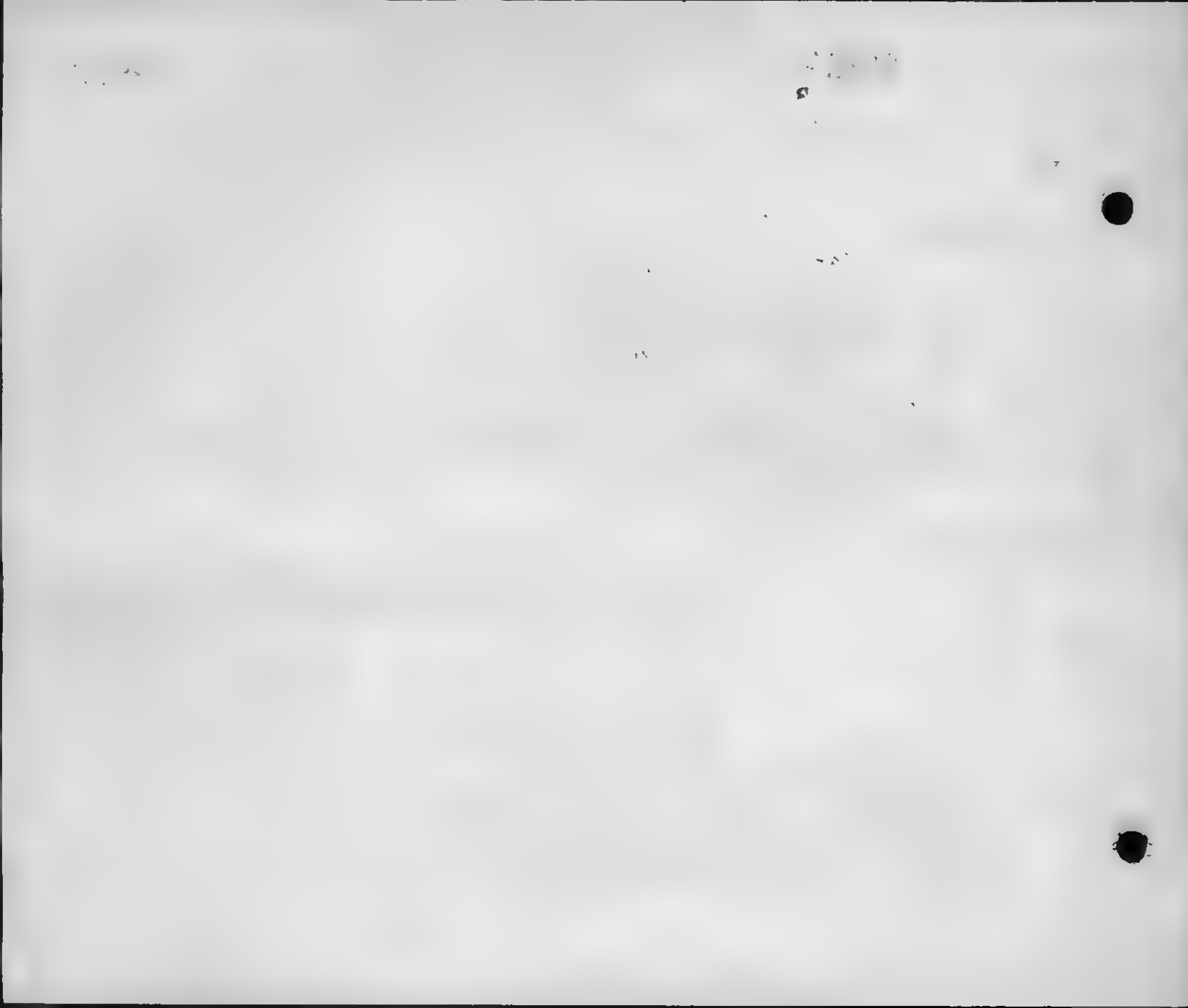
V5. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09876

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY in 1b <u>49 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3536 GLENHURST Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3536 GLENHURST Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>JOSEPH BURAKIEWICZ</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-1895</u>		9. AGE (in years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u>		11. IF UNDER 24 HRS. Hours <u>6</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ESSKAY CO</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POLAND</u>				11. BIRTHPLACE (State or foreign country) <u>U S A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>MICHAEL BURAKIEWICZ</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>23-10-3508</u>				17. INFORMANT <u>HELEN BURAKIEWICZ GLENHURST</u> Address <u>3536 GLENHURST</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>334 X</u> DUE TO (c) <u>30 min</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>9-14-61</u>																			
ACTUAL SIGNATURE <u>Jack Collins</u> EXAMINER'S NAME (Type) <u>JACK COLLINS</u>				DATE SIGNED <u>9-14-61</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>9-16-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>				22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>							
23. FUNERAL DIRECTOR <u>Walter Nabrowski</u> ADDRESS <u>1005 DUNDALK AV.</u>				24a. REC'D BY REGISTRAR <u>SEP 18 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>											



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9886

CERTIFICATE OF DEATH

Reg. Dist. 98877

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fellowship Forest c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 602 Valley Lane				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fellowship Forest d. STREET ADDRESS 602 Valley Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK A. BURGEMEISTER				4. DATE OF DEATH Month Day Year Sept. 4, 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1879		9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurateur- Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Burgemeister				14. MOTHER'S MAIDEN NAME Marie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Robert T. Mohre, 602 Valley Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 15 0.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic congestive failure & Electrolyte imbalance DUE TO (c) Generalized atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH Hours Years Months Years	
21. I certify that I attended the deceased from Sept 4, 19 61 to Sept 4, 19 61 that I last saw the deceased alive on Sept 4, 19 61 , and that death occurred at 9:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7729 GREENVIEW TERRACE TOWSON 4, MD. DATE SIGNED ACTUAL SIGNATURE William H. Kieby, Jr. M.D. PHYSICIAN'S NAME (Type) William H. Kieby, Jr.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 7, 1961		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR DATE SEP 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



9887

CERTIFICATE OF DEATH

Reg. Dist. No. 09878

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MD b. COUNTY BALTIMORE 57 S. MONASTERY AVE. BALT. 24	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 2/1/57-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PICKERSGILL		d. STREET ADDRESS SAME AS ABOVE	
3. NAME OF DECEASED (Type or print) MRS. FLORA First Middle Last		4. DATE OF DEATH Sept 14 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1885
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR 8 Months 27 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS GLANVILLE		14. MOTHER'S MAIDEN NAME KATIE PARKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 220-14-4401	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cerebral Vascular Disease DUE TO (c) Previous C-V-A.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-14 , 19 61 , to 9-14 , 19 61 , that I lost saw the deceased alive on 9-13 , 19 61 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Manland Edmund Day M.D.		ADDRESS (Street, city or town, state) 4-E-33rd St Baltimore 18 Sept 14 1961	
PHYSICIAN'S NAME (Type)		DATE SEP 18 '61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-18-61	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore.		24a. REC'D BY REGISTRAR SEP 18 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-5-9423

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

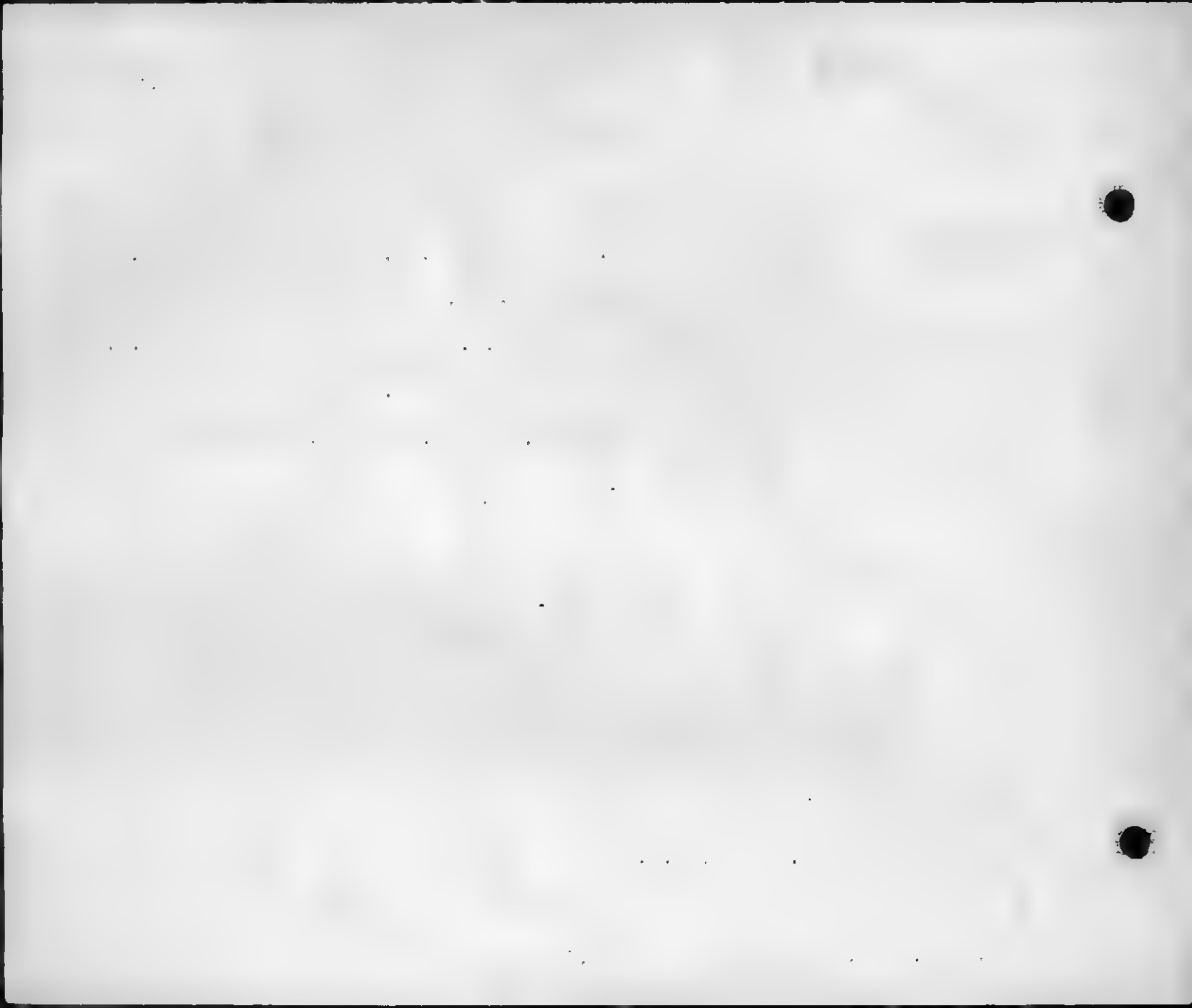
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9888

Reg. Dist. No. 98879

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7615 Gum Road</u>				d. STREET ADDRESS <u>7615 Gum Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>Cantwell, Sr.</u>							
4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1961</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Aug. 15, 1906</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maritime Service</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. County, Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Cantwell</u>			14. MOTHER'S MAIDEN NAME <u>Adeline R. Foster</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? ("Yes, no, or unknown") <u>no</u>		16. SOCIAL SECURITY NO. <u>219-01-7623</u>		17. INFORMANT <u>Mrs. Agnes M. Cantwell, 7615 Gum Road, Zon 22</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Melvin B. Davis</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/26/61</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-29-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</u>			24a. REC'D BY REGISTRAR <u>SEP 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9889

Item 14 Film 6294 9/8/61 ink

09880

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1139 Hollins Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JEAN (MM) CAPPARELLA		4. DATE OF DEATH SEPTEMBER 1 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/87
9. AGE (In years last birthday) 74 Yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY Roofing Company	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dominick Capparella		14. MOTHER'S MAIDEN NAME Mary unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW I		16. SOCIAL SECURITY NO. 218-10-4113	
17. INFORMANT Clint. Rec. VAH, Balto. 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ANTROLATERAL MYOCARDIAL INFARCTION 4-20-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE CORONARY ARTERIOSCLEROSIS (c) THROMBOSIS RIGHT AURICLE PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMBOLUS, RIGHT, PULMONARY INFARCTION, RIGHT, ANTRONEPHROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 8/23/61 to 9/1/61 , that (we) last saw the deceased alive on 9/1/61 , and that death occurred at 9:10AM , from the causes and on the date stated above.			
22a. SIGNATURE Ernest O. Brown, M.D.		22b. DATE SIGNED 9/2/61	
22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-5-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.		25a. REC'D BY REGISTRAR SEP 6 '61	
ADDRESS 6009 Harford Road Baltimore 14, Maryland		25b. REGISTRAR'S SIGNATURE William S. Thomas	

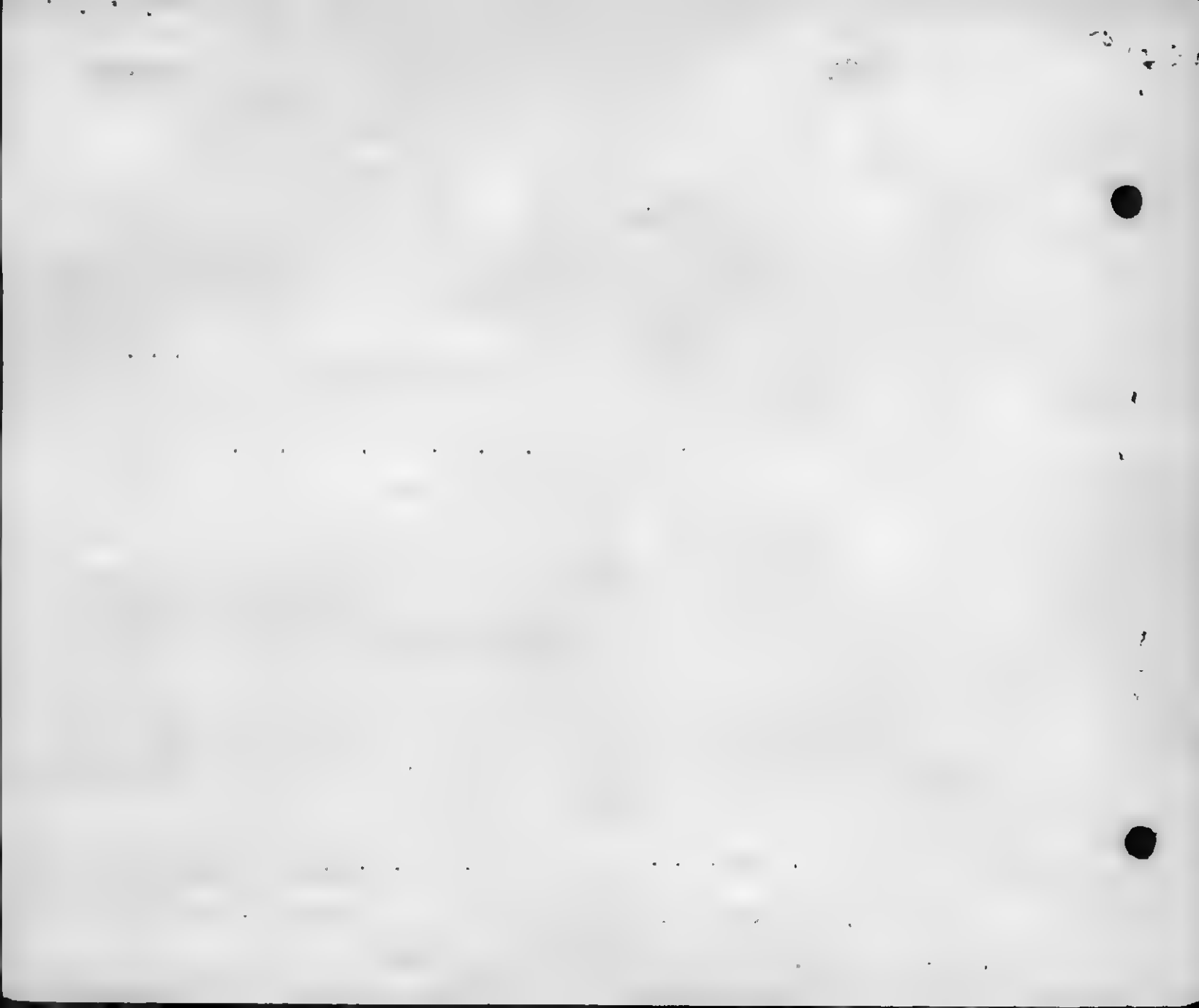
MEDICAL CERTIFICATION

2

050

1

M



1
FOR STATE
HEALTH DEPT.

TO DISTRIBUTE: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09881

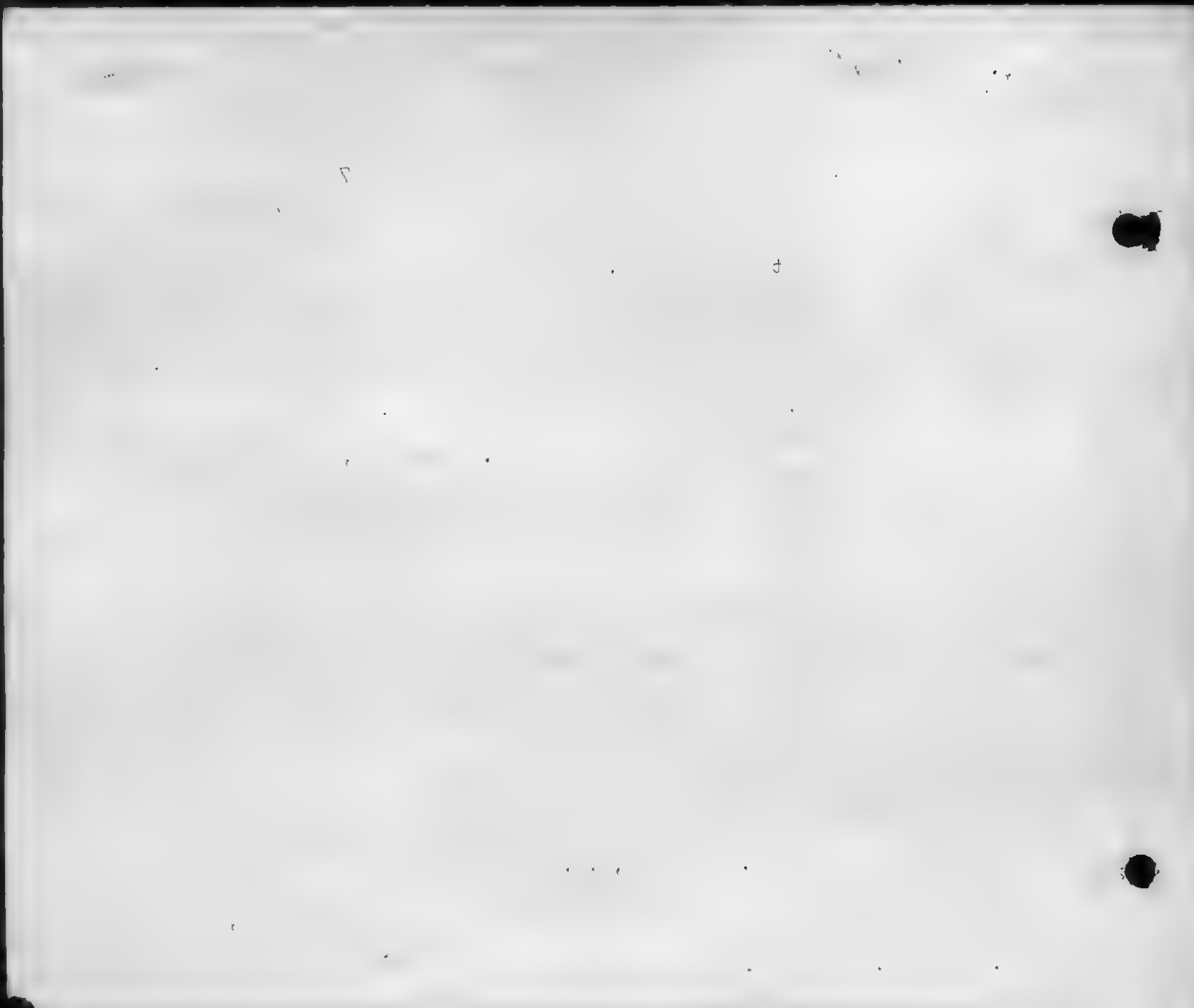
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2800 Page Drive		d. STREET ADDRESS 2800 Page Drive	
3. NAME OF DECEASED (Type or print) BENJAMIN H. CARNES		4. DATE OF DEATH September 5, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1915
9. AGE (In years last birthday) 45 yrs.		10. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Armco Steel Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Benjamin H. Carnes		14. MOTHER'S MAIDEN NAME Louise Neumann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes. WWII		16. SOCIAL SECURITY NO. 7711	
17. INFORMANT Mrs. Frida Carnes		Address 2800 Page Drive-22	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CONCOMITANT DECEASE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1961	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.		24. REC'D BY REGISTRAR DASEP 13 '61	
24b. REGISTRAR'S SIGNATURE Carlton S. Thomas		DATE SIGNED 9/7/61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9891											
CERTIFICATE OF DEATH											
09882											
Item 9 Film G295 9/20/61											
1. PLACE OF DEATH a. COUNTY Baltimore				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 27				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1929 Victory Drive				e. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Baltimore			
3. NAME OF DECEASED (Type or print) Ruth E. Carnes				4. DATE OF DEATH September 14 1961				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX female				6. COLOR OR RACE white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH April 3, 1890				9. AGE (In years last birthday) 71 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant			
11. BIRTHPLACE (County & State, or foreign country) Monroe County, New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles L. Fishbaugh			
14. MOTHER'S MAIDEN NAME Estella M. Sage				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 17. INFORMANT Ralph A. Fishbaugh, 1929 Victory Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> DUE TO IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Psychopathic Reaction, cataplexy type</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 10h			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 14, 1961</i> to <i>Sept. 14, 1961</i> , that (I) (we) last saw the deceased alive on <i>Sept. 14, 1961</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Florian P. Nadolski</i>				22b. DATE SIGNED <i>Sept 14, 61</i>				22c. PHYSICIAN'S NAME (Type) Florian P. Nadolski, M.D.			
22d. ADDRESS <i>2103 Hancock Road, Baltimore 7, Md</i>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/>				22f. MED. DIRECTOR <input type="checkbox"/>			
22g. STAFF PHYS. <input type="checkbox"/>				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 9-16-61			
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial				23d. LOCATION (City, town or county) (State) Glen Burnie, Md				24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street			
24. ADDRESS Wm. Cook, Inc., 1217 St. Paul Street				25a. REC'D BY REGISTRAR DATE SEP 18 '61				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9892

CERTIFICATE OF DEATH

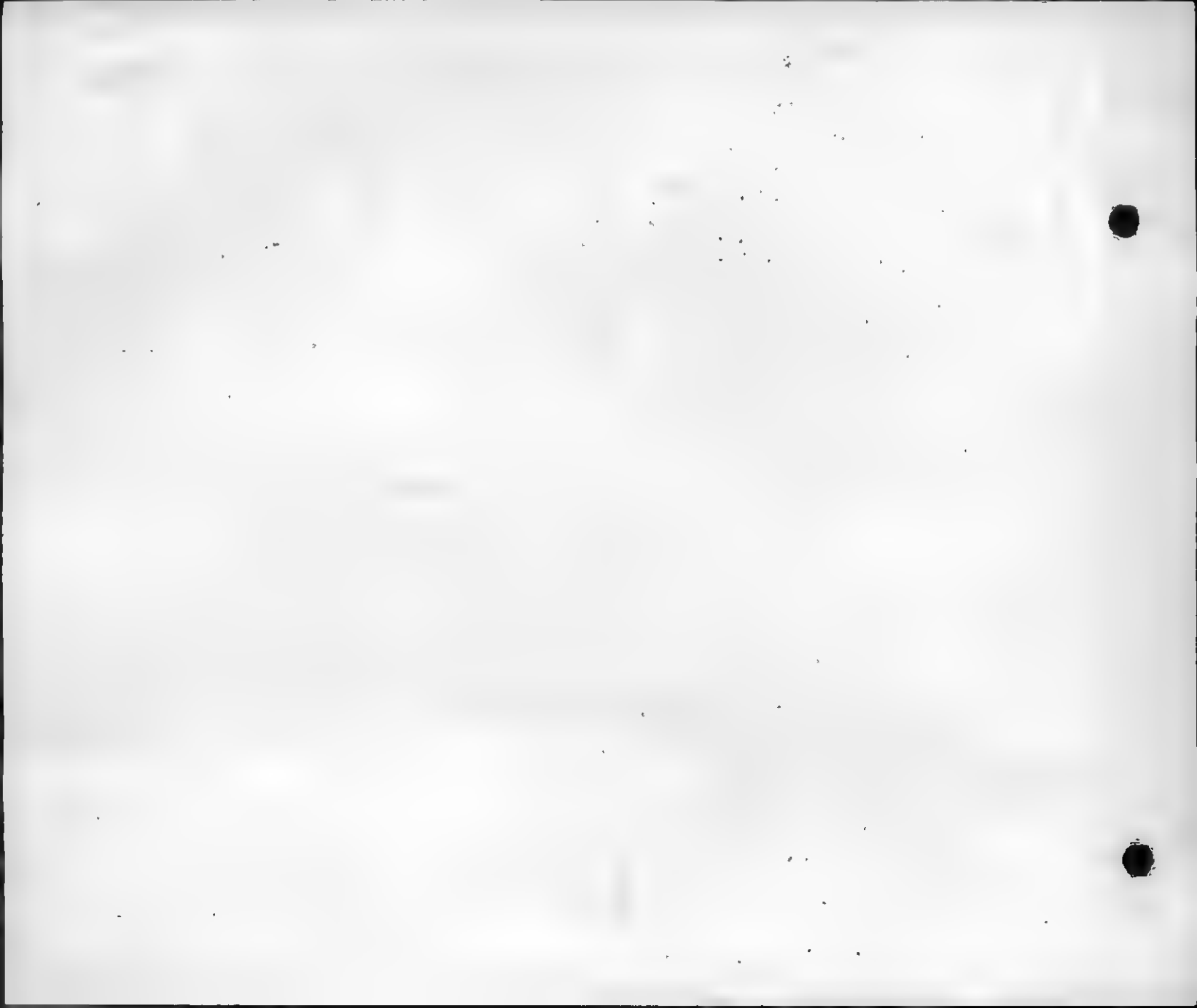
Reg. Dist. No. 09883

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES		d. STREET ADDRESS 207 SOUTH WICKHAM ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last URIAH F. CASSELL		4. DATE OF DEATH Month Day Year SEPT. 5 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1893
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES HENRY CASSELL		14. MOTHER'S MAIDEN NAME ROSA GRACE ALEXANDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES. 5/3/18 TO 6/18/19		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218 05 3412	
17. INFORMANT MRS CAROLYN C. WITZKE		18. ADDRESS 1344 MERIDENE DRIVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete heart block, myocardial insufficiency 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 27, 1959 to Sept. 5, 1961 , that I last saw the deceased alive on Sept. 5, 1961 and that death occurred at 8:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue Baltimore 29, Maryland DATE SIGNED 9/6/61			
ACTUAL SIGNATURE George A. Knipp		M.D. 4116 Edmondson Avenue Baltimore 29, Maryland	
PHYSICIAN'S NAME (Type) George A. Knipp, M.D.		DATE SEP 8 '61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/8/61	
22c. NAME OF CEMETERY OR CREMATORY WESTERN CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE 13, MARYLAND		24a. REC'D BY REGISTRAR SEP 8 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11 & 12 filed 10/6/61 iwk

9893

CERTIFICATE OF DEATH

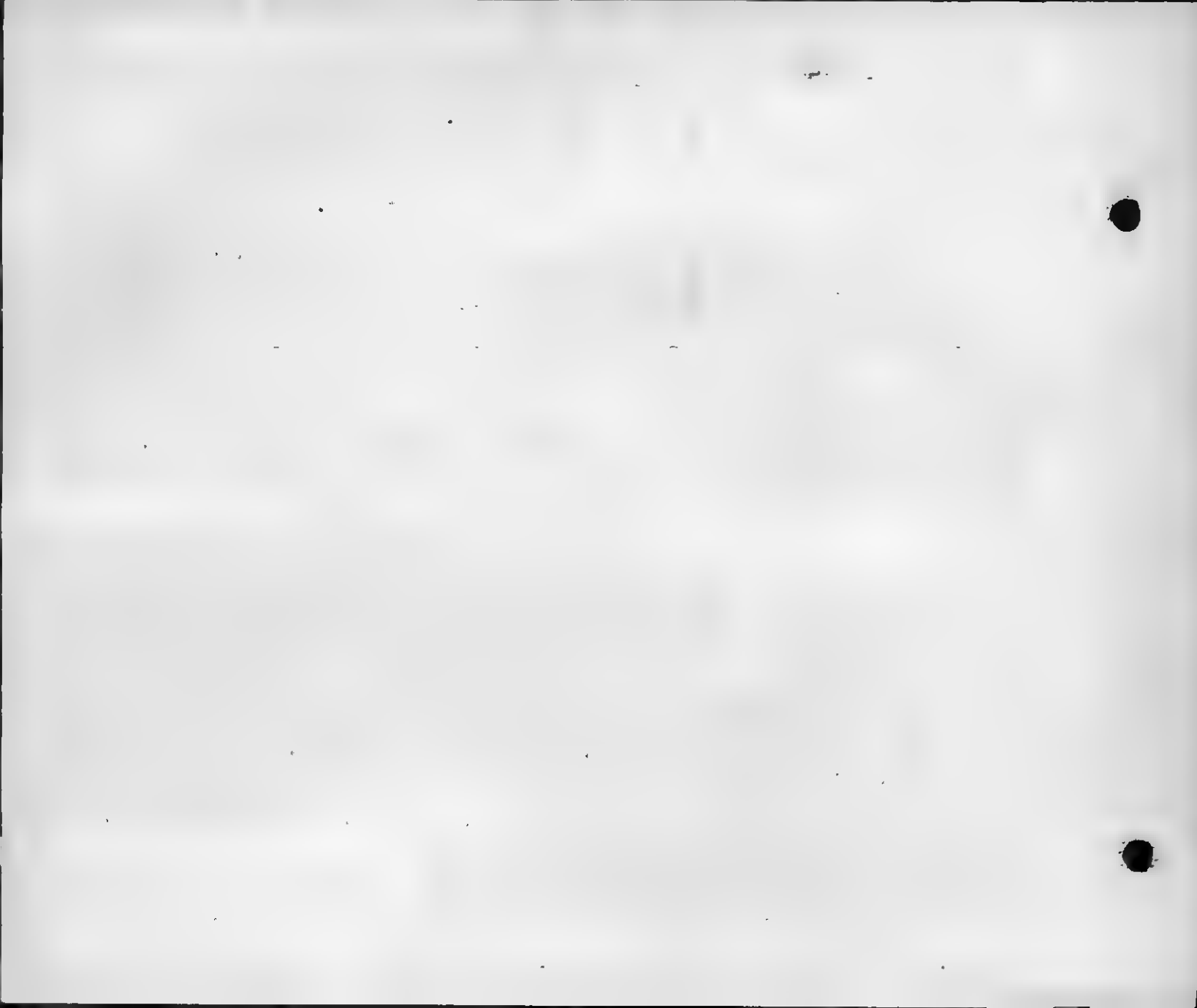
Reg. Dist. No.

09884

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>423 Dumbarton Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth J. Cassidy</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Elmer E. Cassidy</u>		Address <u>423 Dumbarton Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 5, 1961</u> , to <u>Sept. 17th, 1961</u> , that I last saw the deceased alive on <u>Sept. 16th, 1961</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo. W. Murgatroyd</u>		ADDRESS (Street, city or town, state) <u>401 E. 25th. St. Balto. 18, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Geo. W. Murgatroyd</u>		DATE SIGNED <u>Sept 22 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 20, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chenoweth Jr.</u>		ADDRESS <u>3617 Chestnut Ave.</u>	
24a. REC'D BY REGISTRAR <u>Sept 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

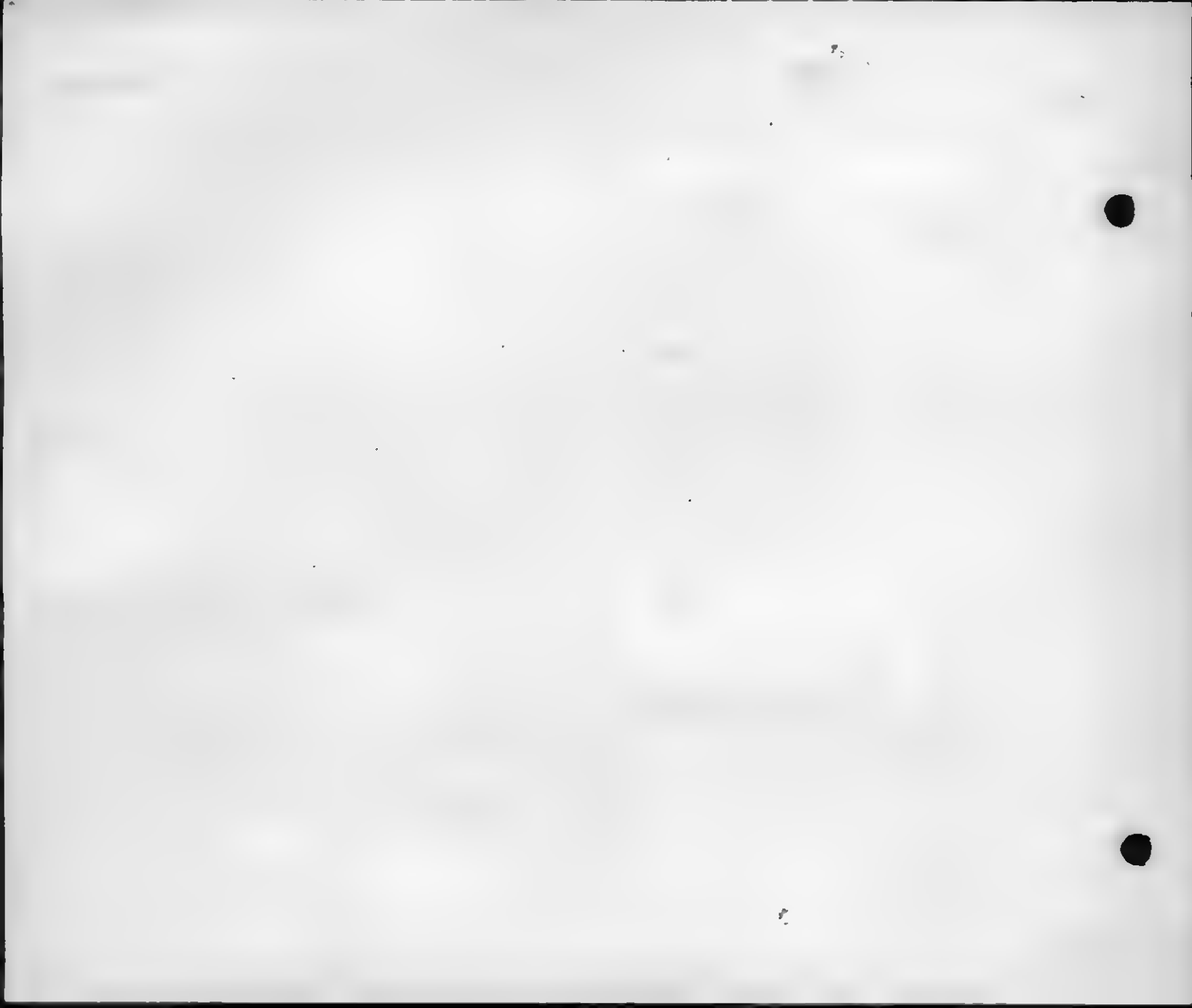
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 42 LEFT WING DRIVE		d. STREET ADDRESS 142 LEFT WING DRIVE	
3. NAME OF DECEASED (Type or print) First HOMER Middle CANTRELL Last CANTRELL		4. DATE OF DEATH Month SEPT Day 14 Year 1961	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 31, 1910
9 AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRONICS		10b. KIND OF BUSINESS OR INDUSTRY MARTINS	
11. BIRTHPLACE (State or foreign country) WATER TOWN TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE CANTRELL		14. MOTHER'S MAIDEN NAME BESSIE VAN TREASE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 408-18-0371	
17. INFORMANT MRS HOMER CANTRELL		Address 42 LEFT WING DRIVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INSUFFICIENCY DUE TO HEPATIC CIRRHOSIS ACUTE & CHRONIC Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) 1 yr DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCTOBER 1958 to SEPT 1961 , that (I) (we) last saw the deceased alive on 9-13-1961 , and that death occurred at 6 AM , from the causes and on the date stated above.			
22a. SIGNATURE John B. Littleton M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1515 MARTIN BLVD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 18, 1961	
23c. NAME OF CEMETERY OR CREMATORY HEARN HILL CEMETERY		23d. LOCATION (City, town, or county) (State) WATERTOWN, TENNESSEE	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road		25a. REC'D BY REGISTRAR SEP 15 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	



1
FOR STATE
HEALTH DEPT
M
TO DEPT OF MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

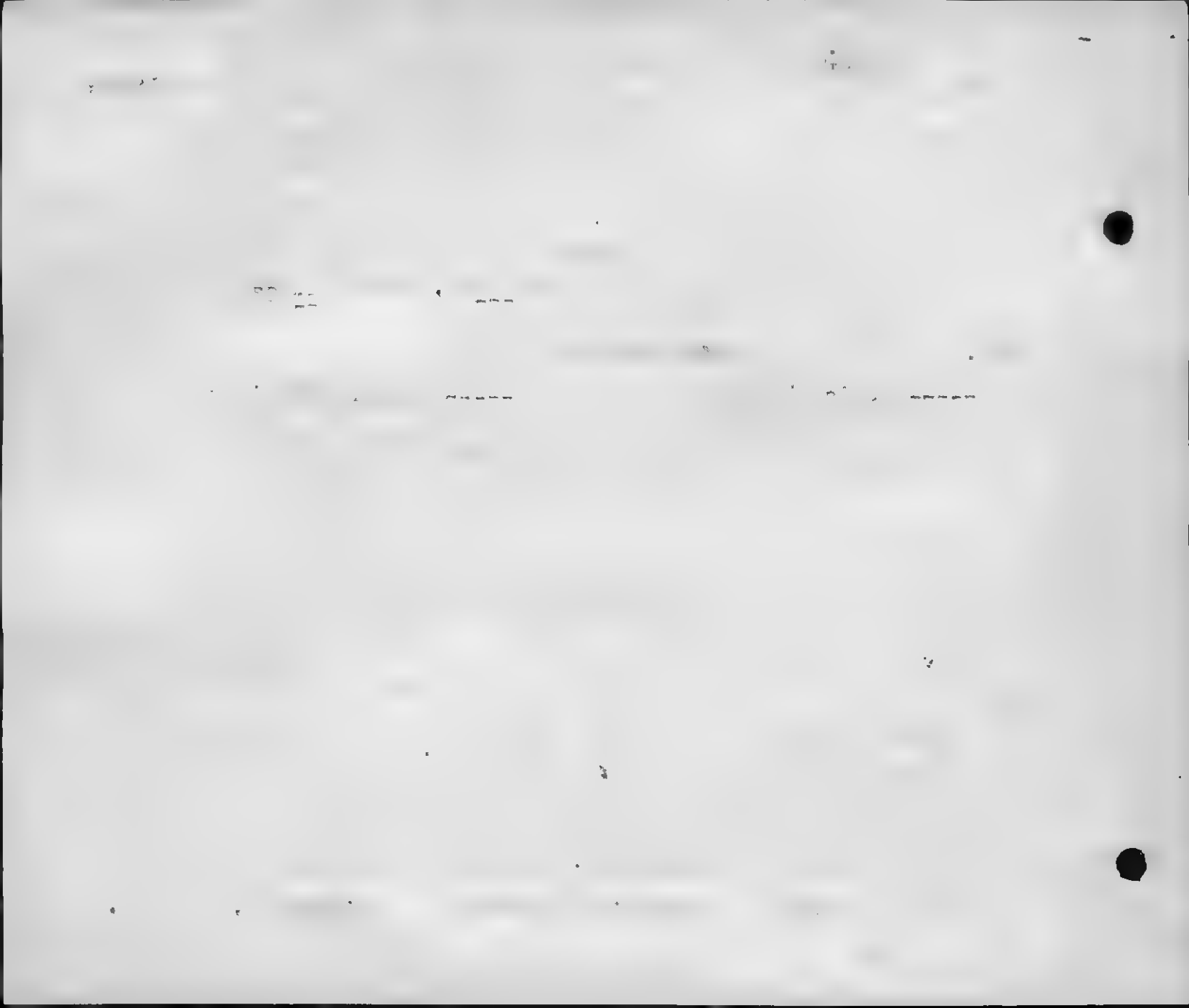
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09886

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b. 5mth15dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution, give institution name and address) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro, Maryland d. STREET ADDRESS General Delivery	
3. NAME OF DECEASED (Type or print) Joseph Samuel Chaney		4. DATE OF DEATH Month September Day 20 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen farming		10b. KIND OF BUSINESS OR INDUSTRY EMP Employed	
13. FATHER'S NAME unknown Louis Chaney		14. MOTHER'S MAIDEN NAME unknown Marir Stallings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 577-10-6452	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-dural hemorrhages DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 936 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. bruises on right side of face and head; apparent bruise of the left eye and bruising on backs of hands; exact cause of findings		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 8-14-61 Pt. found with	
20c. TIME OF INJURY Month, Day, Year 6:30 a.m. 8-14-61		20d. INJURY OCCURRED 1. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	
20f. (City or town) Catonsville		20g. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		DATE SIGNED 9-21-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/61	
22c. NAME OF CEMETERY OR CREMATORY Smithville Cemetery		22d. LOCATION (City, town, or country) Smithville, Md.	
23. FUNERAL DIRECTOR Probie Bros. Upper Marlboro, MD		ADDRESS	
24a. REC'D BY REGISTRAR SEP 29 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	



1 ~~18~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9896 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09887

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence must be given) a. STATE Vo- b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL) Beltz - rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winchester	
c. LENGTH OF STAY IN 1b 4 hrs.		d. STREET ADDRESS 407 MOSBY ST	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 826 Loyola Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEWIS WILLARD CHANTLER		4. DATE OF DEATH SEPT 16 1961	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 June 1895
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Director		10b. KIND OF BUSINESS OR INDUSTRY him & cement	
11. BIRTHPLACE (State or foreign country) Pittsburg Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISREAL CHANTLER		14. MOTHER'S MAIDEN NAME Annie Staeb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. same (wife)	
17. INFORMANT Laura Chantler		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion		Interval	
DUE TO (b) Hypertensive Cardiovascular Disease		Under	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		DATE SIGNED 9-16-61	
EXAMINER'S NAME (Type) JOHN C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-18-61	
22c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jackson & Sons		24a. REC'D BY REGISTRAR SEP 19 '61	
ADDRESS Beltz 14, Md.		24b. REGISTRAR'S SIGNATURE William J. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9897

09888

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN TB _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>121 Glenmore Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> d. STREET ADDRESS <u>121 Glenmore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Clayd W Clark</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Mar. 1, 1905</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elec Engineer Westinghouse</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Herbert Clark</u>	
14. MOTHER'S MAIDEN NAME <u>Mary V. Burman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>19-20-5932</u>	
16. SOCIAL SECURITY NO. <u>219-20-5932</u>		17. INFORMANT <u>Mrs. Jane Clark w if</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Liver and Omentum</u> (b) <u>Adenocarcinoma of Esophagus</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>150X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from... 12-8-1960, to 9-12-1961, that (I) (we) last saw the deceased alive on... 9-11-1961, and that death occurred at 11:44 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter K. Gallager</u> M.D.		22b. DATE SIGNED <u>9-14-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter K. Gallager, M.D.</u>		22d. ADDRESS <u>6204 Frederick Ave, Baltimore 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/15/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town or county) <u>Balto. 7. md</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wittke</u>		25a. REC'D BY REGISTRAR <u>SEP 15 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>John S. Huns</u>		25c. ADDRESS <u>401 Edmondson Ave</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



1
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, the delay should be noted in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
 a. COUNTY Baltimore
 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Daniels
 c. LENGTH OF STAY IN 1b 20 years
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 93 Lower Brick Row

2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution)
 a. STATE Maryland
 b. COUNTY Baltimore
 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Daniels
 d. STREET ADDRESS 93 Lower Brick Row

3. NAME OF DECEASED
 (Type or print) WILMER FRANKLIN COLE

4. DATE OF DEATH
 Month Sept. Day 4 Year 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH May 1, 1906
 9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR: Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cotton Mill
 10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill
 11. BIRTHPLACE (State or foreign country) Virginia
 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Cole 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No
 16. SOCIAL SECURITY NO. 237-10-9565 17. INFORMANT Jack Cole, 18 Upper Brick Row, Daniels, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
 (PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Coronary Thrombosis
 DUE TO (b) Cardiovascular disease
 DUE TO (c)
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
 PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE C.E.O. S.M. KIEFFER M.D. CHIEF MEDICAL EXAMINER
 EXAMINER'S NAME (Type) C.E.O. S.M. KIEFFER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED 10/10/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-7-61 22c. NAME OF CEMETERY OR CREMATORY Daniels 22d. LOCATION (City, town, or country) Daniels, Md (State)

23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md ADDRESS 24a. REC'D BY REGISTRAR SEP 6 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hines



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9899

9899

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. STREET ADDRESS Glenarm, Maryland	
3. NAME OF DECEASED (Type or print) Sister Mary Elinor First Middle Last		4. DATE OF DEATH 9 21 19 61 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec, 12, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Religious.	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William Collins		14. MOTHER'S MAIDEN NAME Catherine Byrne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Henrica		Address Villa Maria, Glenarm, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 3 30 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sub-arachnoid hemorrhage DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 da. 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 19 55 to September 19 61 , that I last saw the deceased alive on September 19 61 , and that death occurred at 4:30 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.			
NAME (Type) Charles F. O'Donnell 7501 York Road Towson 4, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-25-61.	22c. NAME OF CEMETERY OR CREMATORY Villa Maria Cemetery	22d. LOCATION (City, town, or county) (State) Notch Cliff nr Towson, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Galar		24a. REC'D BY REGISTRAR 901 S. Conkling St.	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9900									
CERTIFICATE OF DEATH									
Item 4 Film G297 10/2/61 mh									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 6yr9mth19dys		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Deal, Maryland		f. STREET ADDRESS none		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First		Middle		Last		4. DATE OF DEATH Month September Day 23 Year 1961	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1908		9. AGE (in years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Crandall		14. MOTHER'S MAIDEN NAME Susan Parks		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown		16. SOCIAL SECURITY NO unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident		DUE TO (b) Hypertensive Arteriosclerotic Cardiovasc. Disease		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		Central Nervous System Syphilis (Meningoencephalitis)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) Deal, Md		(County) (State)	
21. I certify that (this hospital) attended the deceased from Dec. 2, 1954 to Sept. 23, 1961 , that (I) (we) last saw the deceased alive on Sept. 23, 1961 , and that death occurred at 5:45 M. from the causes and on the date stated above.		22a. SIGNATURE Jose R. Cruzaga		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jose R. Cruzaga		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-26-61		23c. NAME OF CEMETERY OR CREMATORY Shenbert		23d. LOCATION (City, town or county) Deale, Md		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE A. Hardesty + Son		ADDRESS Catonsville, Md		25a. REC'D BY REGISTRAR SEP 27 '61		25b. REGISTRAR'S SIGNATURE Arthur J. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

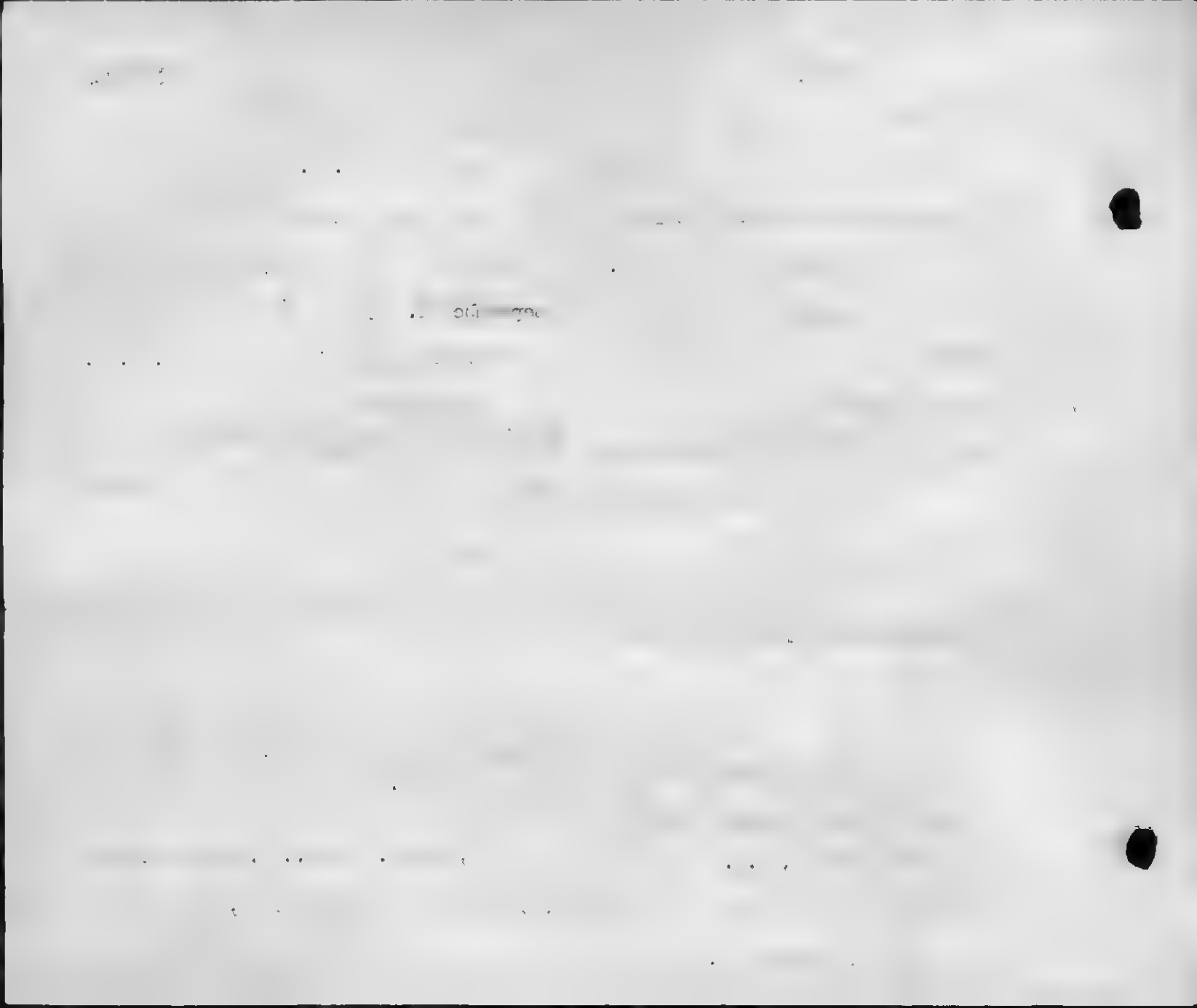
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9901

09892

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND Virginia		b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY (In days) 45 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hornstown P. O.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Star Route Sinnickson		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BENJAMIN F. CROPPER		4. DATE OF DEATH September 24 1961		5. AGE (In years, last birthday) 66 yrs.	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH September 10, 1895		9. AGE (In years, last birthday) 66 yrs.		10. MONTHS 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. PLACE (City & State, or foreign country) Wattsville, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Cropper		14. MOTHER'S MAIDEN NAME Mary Cropper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-18-4460		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 177X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR +	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 177X		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. TIME OF INJURY Month, Day, Year 19		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from August 10 1961 to Sept. 24 1961 , that (b) (we) last saw the deceased alive on September 24 1961 , and that death occurred at 5:35 P.M. from the causes and on the date stated above.		22a. SIGNATURE Sebastian Russo, M.D.		22b. DATE SIGNED 9/25/61	
22c. PHYSICIAN'S NAME (Print) SEBASTIAN RUSSO, M.D.		22d. ADDRESS VAH, BALTO. 18 MD., FT. HOWARD DIVISION		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9-28-61		23c. NAME OF CEMETERY OR CREMATORY Wattsville, Cemetery	
23d. LOCATION (City, town or county) (State) Wattsville, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton, New Church, Virginia		25a. REC'D BY REGISTRAR SEP 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE SEP 28 '61		25d. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

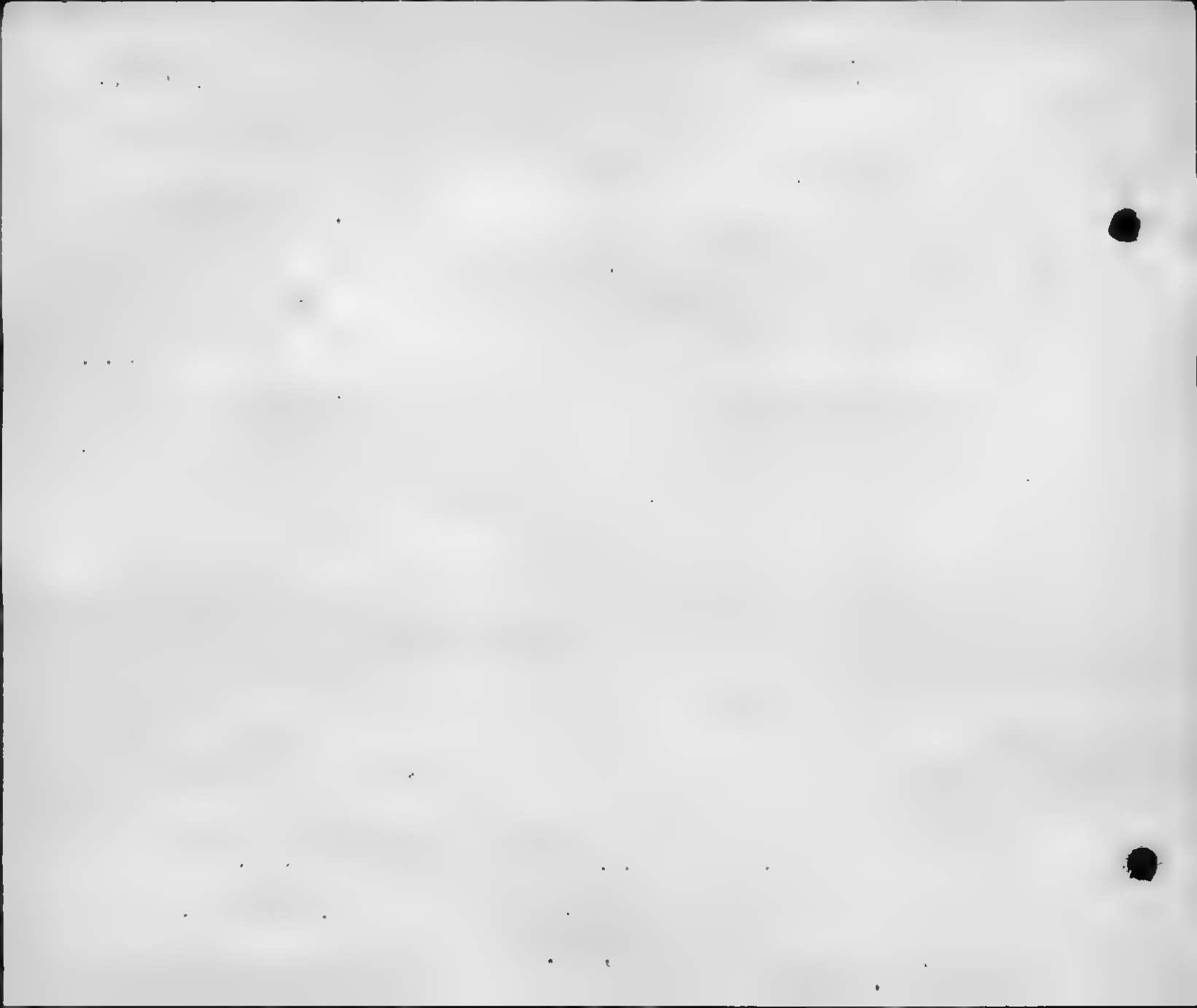
9902

09893

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 11/10/58	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS -653 W. Bel Air Ave	
3. NAME OF DECEASED (Type or print) First Walter Middle B. Last Cummings		4. DATE OF DEATH Month 9 Day 1 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/02
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or country) Aberdeen, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Cummings (deceased)		14. MOTHER'S MAIDEN NAME Lydia Hinkson Cummings (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMATION Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchopneumonia 1191X } DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism with severe mental deficiency			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from 11-10-58 to 9-1-61 , that (H) (we) last saw the deceased alive on 9-1-1961 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward J. Mathews 22c. PHYSICIAN'S NAME (Type) Edward J. Mathews, M.D.		22b. DATE SIGNED 9-1-61 22d. ADDRESS Rosewood State Training School Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/3/1961	23c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	23d. LOCATION (City, town or county) (State) RD. Aberdeen, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring John G. Tarring		25a. REC'D BY REGISTRAR SEP 6 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Finney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

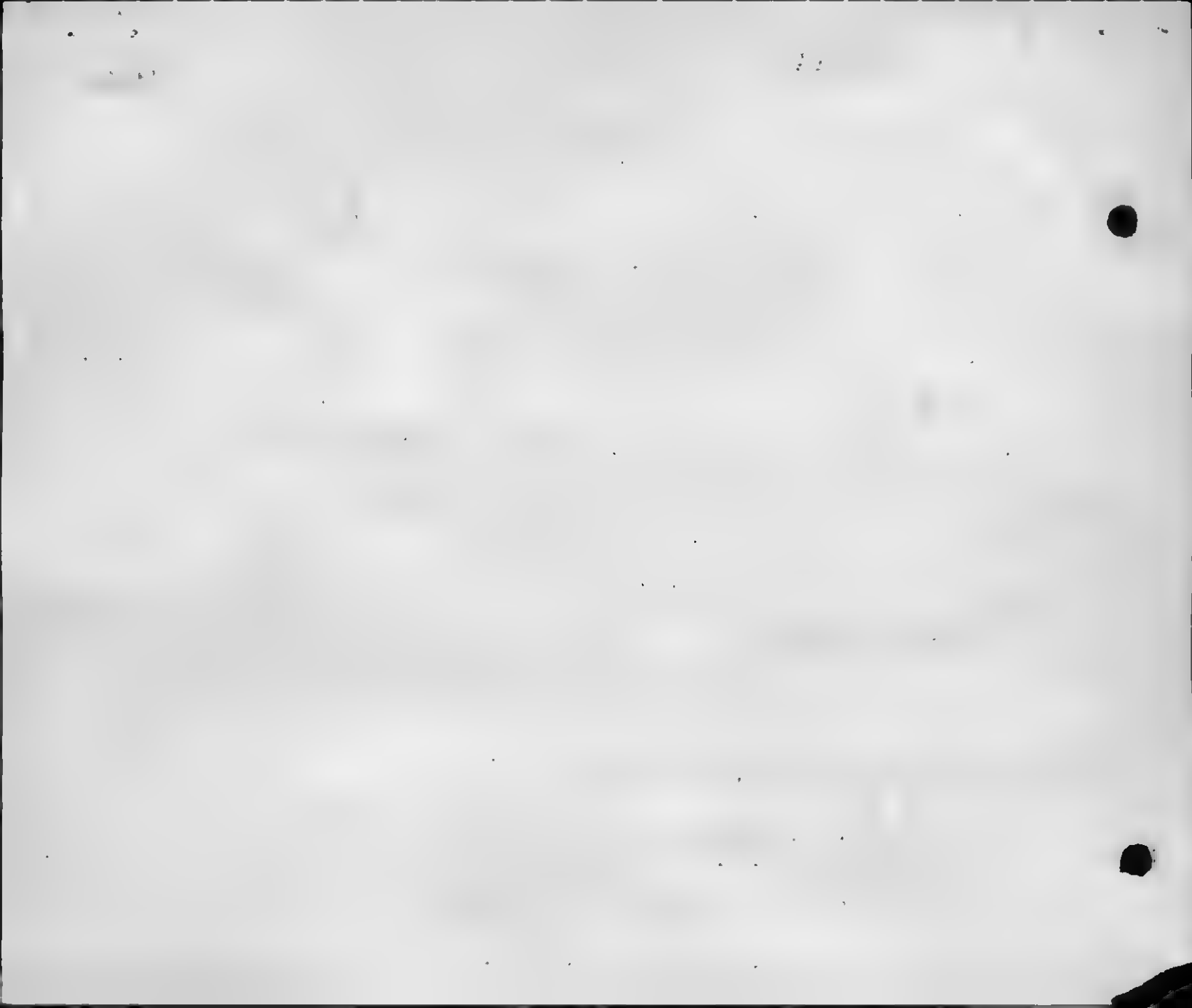
VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOS- L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9903											
09894											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						c. LENGTH OF STAY IN 1b 2 Days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 6413 Belair Road					
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL J. DE MARCO						4. DATE OF DEATH Month Day Year September 29 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/29/92		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist						10b. KIND OF BUSINESS OR INDUSTRY Drugs					
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Disipino DeMarco						14. MOTHER'S MAIDEN NAME Josephine Cammaraja					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I						16. SOCIAL SECURITY NO. 220-05-3555					
17. INFORMANT Clinical Records, VAH, Fort Howard Division						Address Baltimore 18, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-2-1 ANTEROLATERAL MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) POLYP, COLON PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). CHRONIC NEPHROSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS UNKNOWN UNKNOWN					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTIMORE		20g. (County) Md.		20h. (State) Md.	
21. I certify that (u) (this hospital) attended the deceased from Sept. 27 1961, to Sept. 29 1961, that (u) (we) last saw the deceased alive on Sept. 29 1961, and that death occurred at A.M. from the causes and on the date stated above.											
22a. SIGNATURE SEBASTIAN RUSSO, M. D.						22b. DATE SIGNED 9/29/61					
22c. PHYSICIAN'S NAME (Typed) SEBASTIAN RUSSO, M. D.						22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/61		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town or county) BALTIMORE		23e. (State) Md.		23f. (Country) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck & Sons, 5305 Harford Rd., Balto. 14						25a. REC'D BY REGISTRAR DATE OCT 3 '61					
25b. REGISTRAR'S SIGNATURE Charles S. Evans											



FOR STATE
HEALTH DEPT.

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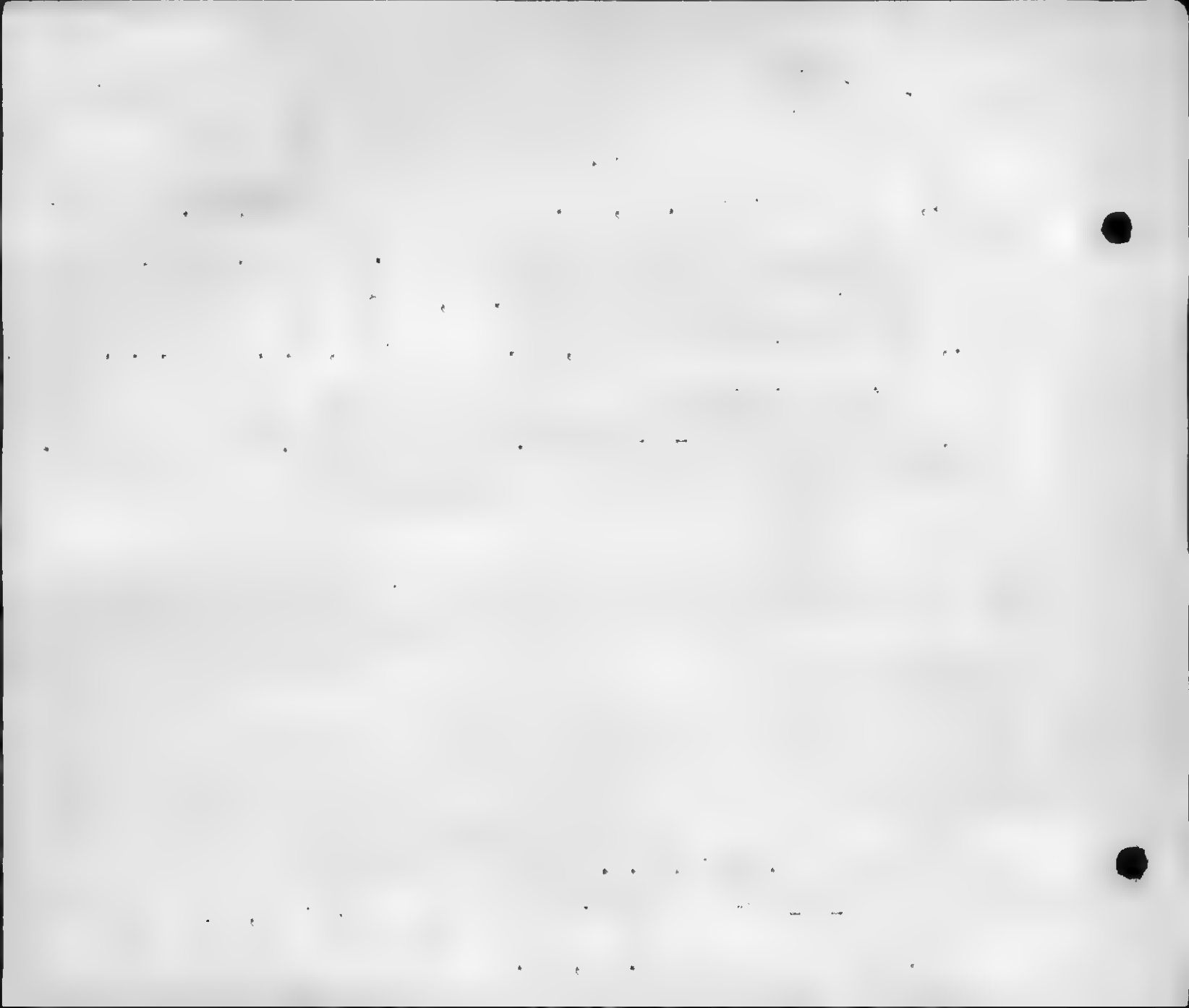
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9904

Reg. Dist. No. 99895

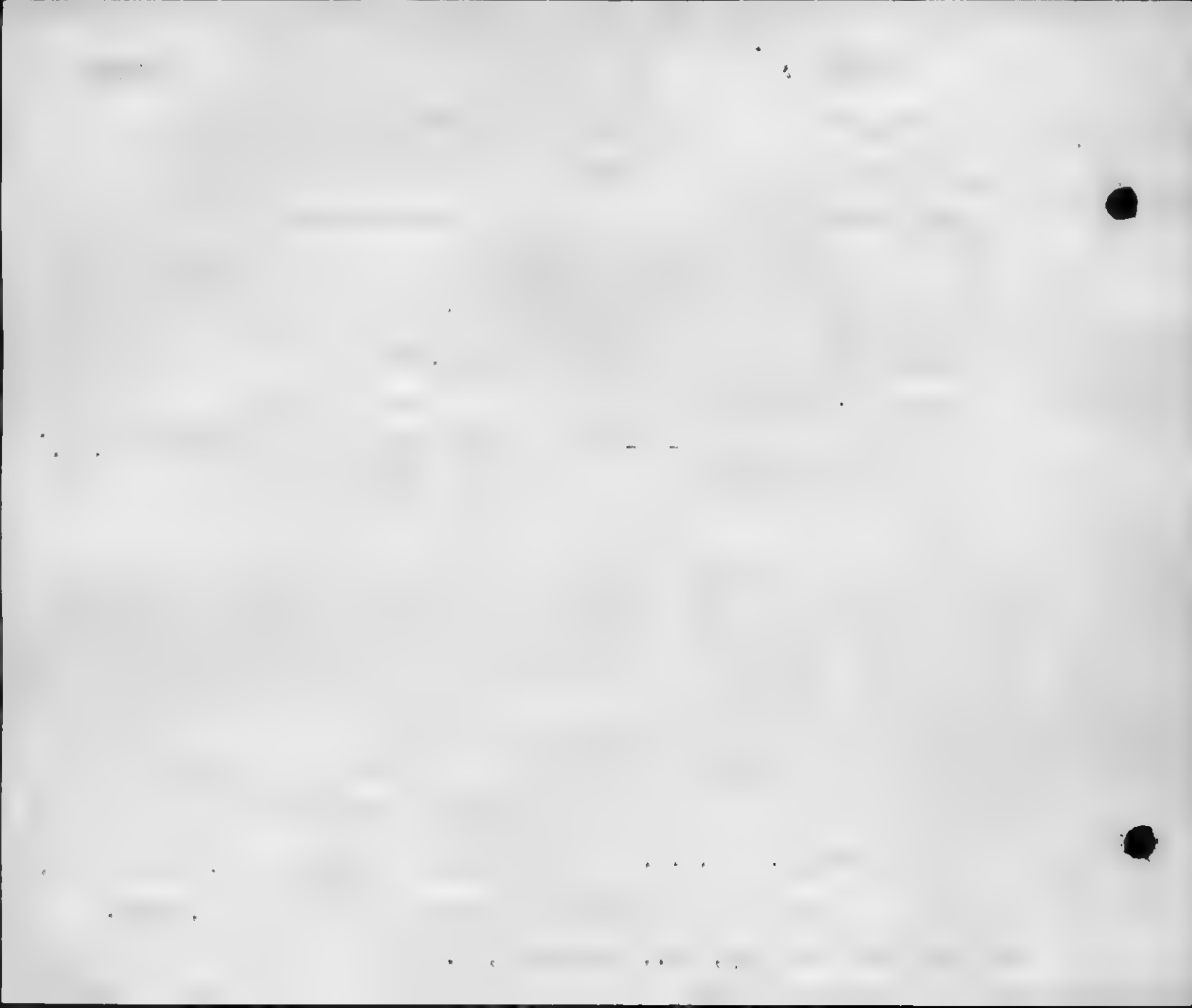
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 14 Waterview Rd. 22, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
3. NAME OF DECEASED (Type or print) HARTMAN FRAZIER DILLINGHAM, SR.		4. DATE OF DEATH Month Sept. Day 27, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1910
9. AGE (In years, month, day) 51 yrs.		10. IF UNDER 1 YEAR Months 51 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret., Policeman in Newport News, Va.		10b. KIND OF BUSINESS OR INDUSTRY Asheville, N.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tilden Dillingham		14. MOTHER'S MAIDEN NAME Grace Tucker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Army, Cavalry		16. SOCIAL SECURITY NO. 246-09-8752	
17. INFORMANT Mrs. Ruth Dillingham, 14 Waterview Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO Coronary Occlusion (c) 420.1 DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 0 p. m. 0		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis		DATE SIGNED 9/28/61	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 9-30-1961	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Asheville, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR OCT 2 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9905 CERTIFICATE OF DEATH 09896											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2519 Yorkway							
3. NAME OF DECEASED (Type or print) HENRY LEWIS DuCHATEAU				4. DATE OF DEATH September 17th 19 61				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1884		9. AGE (In years last birthday) 77 yrs		10. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blower				10b. KIND OF BUSINESS OR INDUSTRY Glass				11. BIRTHPLACE (County & State, or foreign country) Jumet, Belgium		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul A. DuChateau				14. MOTHER'S MAIDEN NAME Aline Sciffet							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO 191-01-3564				17. INFORMANT Armand DuChateau Address 1924 Merritt Blvd. Baltimore 22, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 20012 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma of the lymph node. (c) Hypertension Generalized arteriosclerosis PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from April 14, 19 39 to Sept 16, 19 61 , that (I) (yes) last saw the deceased alive on Sept 16, 19 61 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Eugene F. Nevy, M.D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9/17/61											
22c. PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D. 22d. ADDRESS 7001 Mornington Road, Dundalk 22, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/20/61 23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial 23d. LOCATION (City, town or county) (State) Point Marion, Penna.											
24. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md. ADDRESS SEP 21 '61 25a. REC'D BY REGISTRAR Arthur S. Kraus 25b. REGISTRAR'S SIGNATURE											



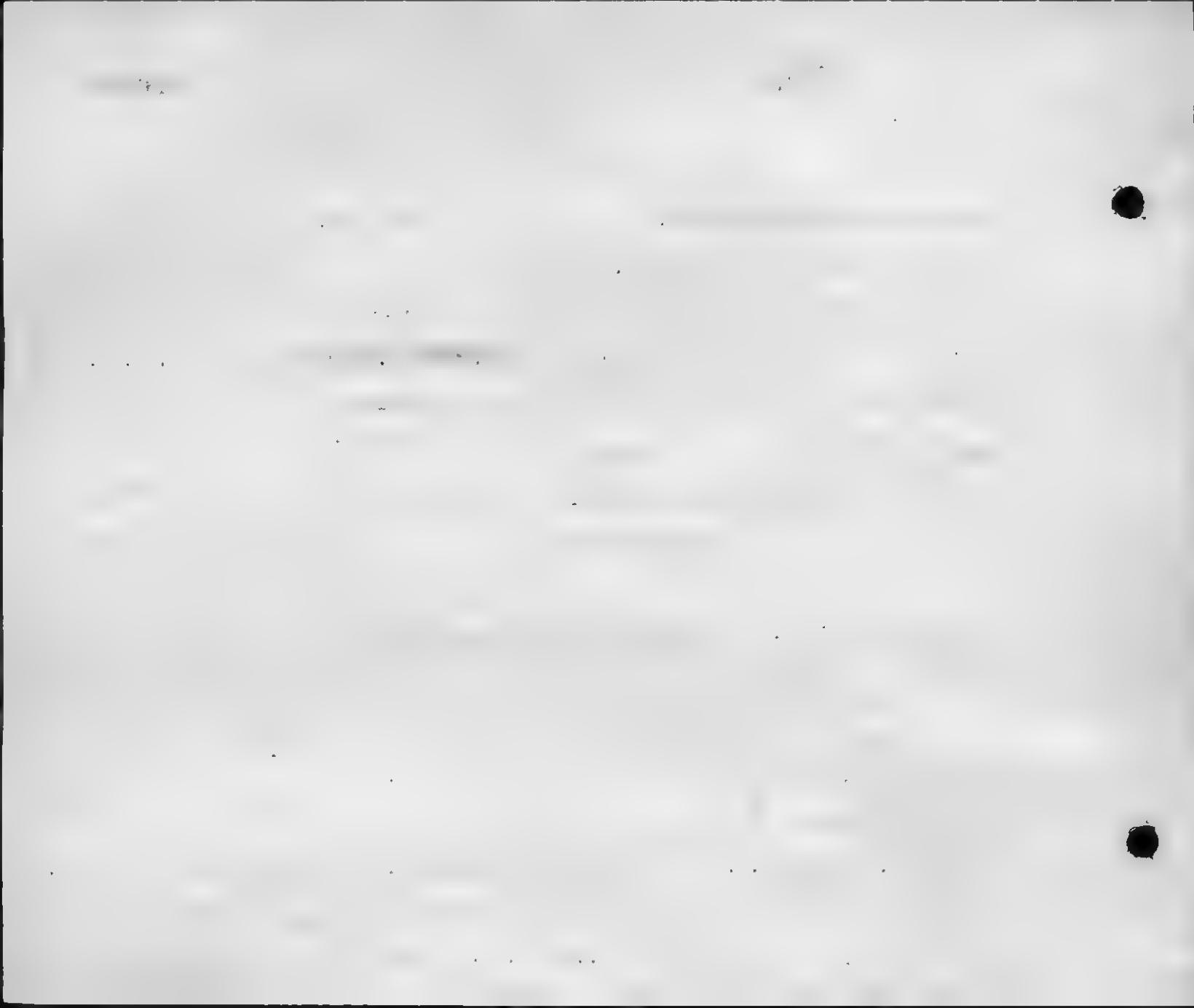
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; if not, last residence prior to admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		b. COUNTY Baltimore	
c. LENGTH OF STAY IN TB 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1307 Edmondson Avenue	
3. NAME OF DECEASED (Type or print) WILLIAM R. EATON		4. DATE OF DEATH September 27 19 61	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1902	
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
11. BIRTHPLACE (County & State, or foreign country) Louisburg, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Eaton		14. MOTHER'S MAIDEN NAME Rebecca Ridley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 188-10-0031	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRO-THROMBOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus. Hypertensive Vascular Disease	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Sept. 25, 1961 , to Sept. 27, 1961 , that (we) last saw the deceased alive on Sept. 27, 1961 , and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 9/28/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO. 18, MARYLAND, FORT HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Oct. 2-1961	
23c. NAME OF CEMETERY OR CREMATORY Hampton National Cemetery		23d. LOCATION (City, town or county) (State) Hampton, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Johnson		25. REC'D BY REGISTRAR SEP 29 '61	
25a. ADDRESS 1700 Druid Hill Ave., Balto. Md.		25b. REGISTRAR'S SIGNATURE Clifford L. Hanna	



1

4

the funeral director, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

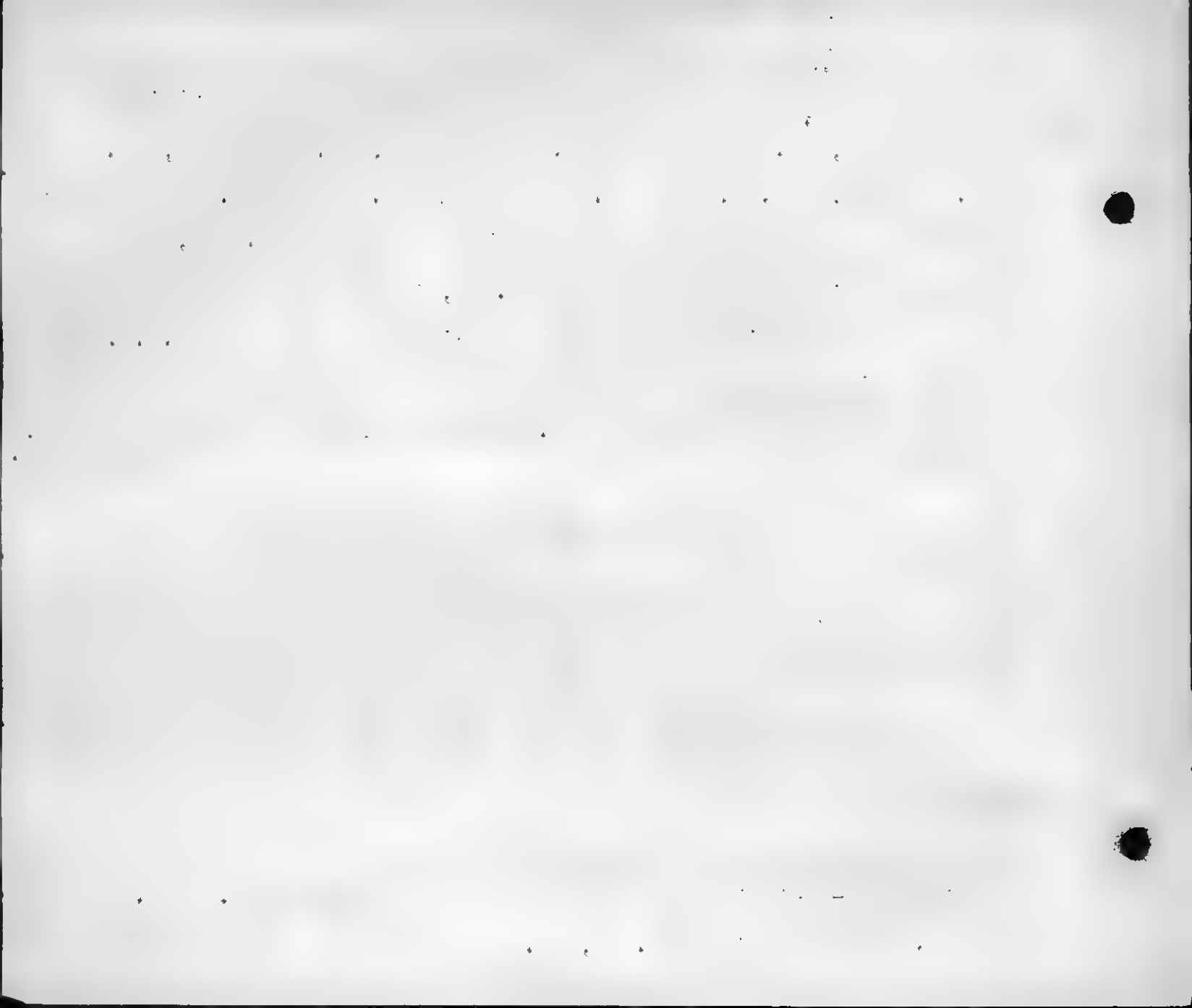
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence given in parentheses) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Todds Farm, Ft. Howard		c. LENGTH OF STAY IN It 31 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. Box 162, Ave. B. Ross Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Todds Farm, Ft. Howard 19, Md.	
3. NAME OF DECEASED (Type or print) First ALMA Middle EKHOLM Last EKHOLM		4. DATE OF DEATH Month Sept. Day 20, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR: Months 80 Days 80 Hours 80 Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Finland	
11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lindholm		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Gunnar Ekholm		Address Box 162 Todds Farm 19, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 31 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis - generalized DUE TO 20 yrs. (c) 20 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month 11 Day 19 Hour 9:15 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9:15 , 19 61 , to 9:20 , 19 61 , that I last saw the deceased alive on 9:15 , 19 61 , and that death occurred at 2 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 520 28th St Balt 19 Md DATE SIGNED 9:21	
ACTUAL SIGNATURE ROGER G. WINOSOR		M.D. 520 28th St Balt 19 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1961	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR SEP 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Haves	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9908											
09899											
1. PLACE OF DEATH a. COUNTY <u>Catonsville Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Catonsville</u> c. LENGTH OF STAY N1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: hospital, date of admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>922 Calwell Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Emily</u> Last <u>Eline</u>						4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1961</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>						8. DATE OF BIRTH <u>August 5, 1876</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						11. BIRTHPLACE (County & State) <u>Maryland</u>					
13. FATHER'S NAME <u>Rheinhold W. Kaul</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jane Carr</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						17. INFORMANT <u>Mrs. Vera G. Wolfe</u> Address <u>922 Calwell Road</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422 cl</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerotic C.V. dis.</u> (a), stating the underlying cause last. (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from... <u>1950</u> to <u>Sept 3, 1961</u> , that (I) (we) last saw the deceased alive on... <u>Aug 19, 1961</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>I. EARL PASS</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>9-5-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>											
22d. ADDRESS <u>4001 W. Chas. Ave. Baltimore</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-6-61</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>											
23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Schenck</u> ADDRESS <u>Balto 17, Maryland</u>											
25a. REC'D BY REGISTRAR <u>SEP 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. J. Schenck</u>											



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

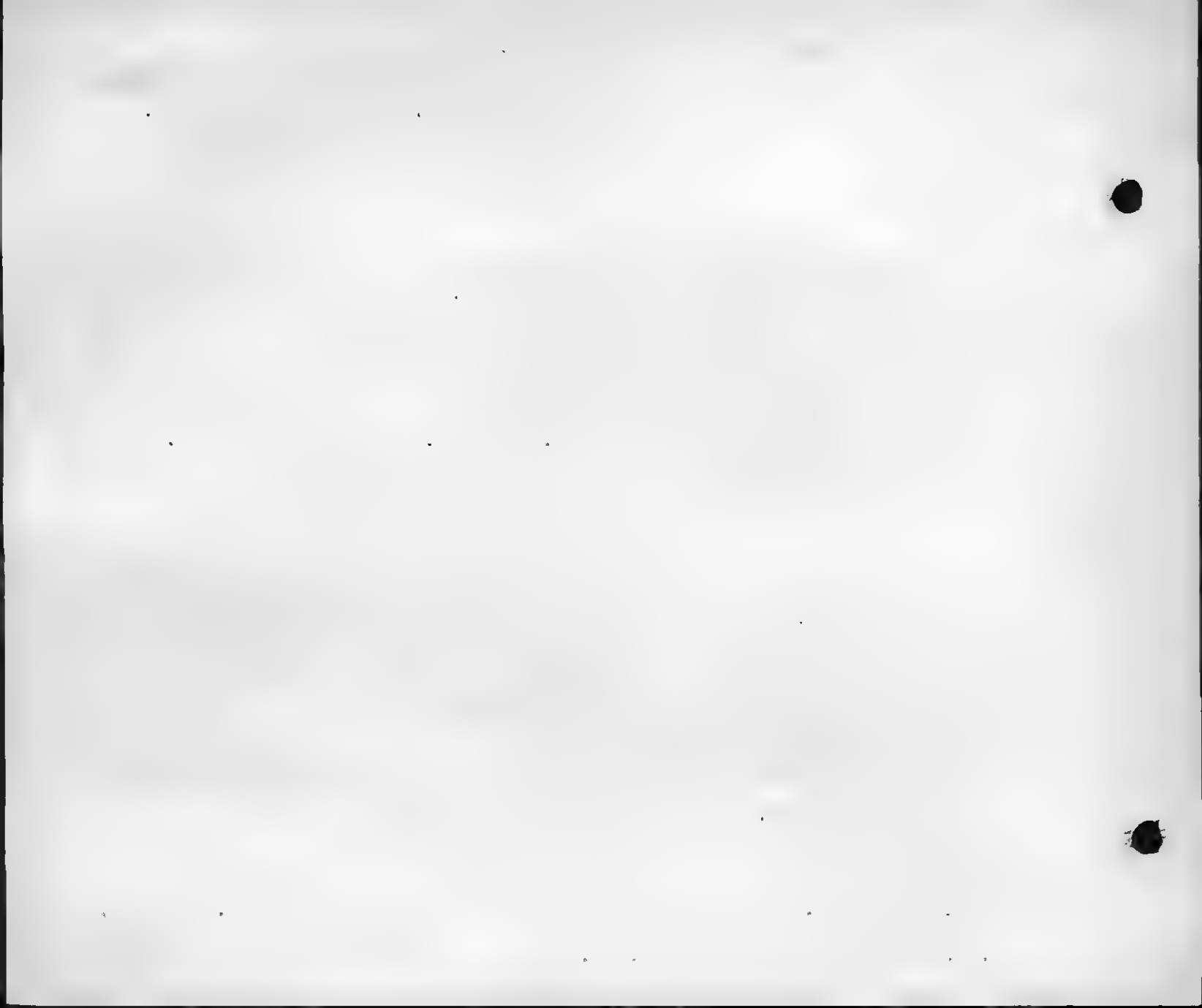
VR A15 (4)
15M 9/59

9909

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09900

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hanover Road		d. STREET ADDRESS Hanover Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgia Middle Rebecca Last Eyler		4. DATE OF DEATH Month Sept Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1890
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR: Months 11 Days 12 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Bozman		14. MOTHER'S MAIDEN NAME Salley Nutter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Thomas R. Eyler		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon 15. DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) metastatic Carcinoma to Liver		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 8, 1961 to Sept 12, 1961 , that (I) (we) last saw the deceased alive on Sept 8, 1961 , and that death occurred at 4:45 AM from the causes and on the date stated above.			
22a. SIGNATURE W. H. Foard		22b. DATE SIGNED Sept 12, 1961	
22c. PHYSICIAN'S NAME (Type) W. H. Foard M.D.		22d. ADDRESS Manchester, Md 9-12-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery		23d. LOCATION (City, town or county) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons Reisterstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>9910</div> </div> <div> <div>M</div> <div>I</div> </div> </div> <div> <div> <div>99901</div> <div>1</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b. 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; residence prior to admission) a. STATE Maryland b. COUNTY Baltimore - 9 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6212 Lincoln Avenue d. STREET ADDRESS 6212 Lincoln Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EMILE M. FISHER 5 SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF DEATH September 23 19 61 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor 11. BIRTHPLACE (County & State, or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Harris Fisher 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1 16. SOCIAL SECURITY NO 217-07-1648 17. INFORMANT Clinical Records, VA Hospital					14. MOTHER'S MAIDEN NAME Esther 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA (b) ASPIRATION (c) ACUTE REACTIVE DEPRESSION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Status postoperative, CA of the colon. Operation: Resection of ca of colon, 7/3/61 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 61 Hour a.m. 1 p.m. 1 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Baltimore (County) Maryland (State) Maryland				
21. I certify that D (this hospital) attended the deceased from Sept. 15 19 61 to Sept. 23 19 61 that I (we) last saw the deceased alive on Sept. 23 19 61 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.					22a. SIGNATURE Frederick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. 22b. DATE SIGNED Sept. 23 19 61 22d. ADDRESS VAH, Baltimore 18, Md. Fort Howard Division				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-24 61 23c. NAME OF CEMETERY OR CREMATORY Kurlander Cemetery 23d. LOCATION (City, town or county) Baltimore (State) Maryland					24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc. 25a. REC'D BY REGISTRAR SEP 26 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9911

CERTIFICATE OF DEATH

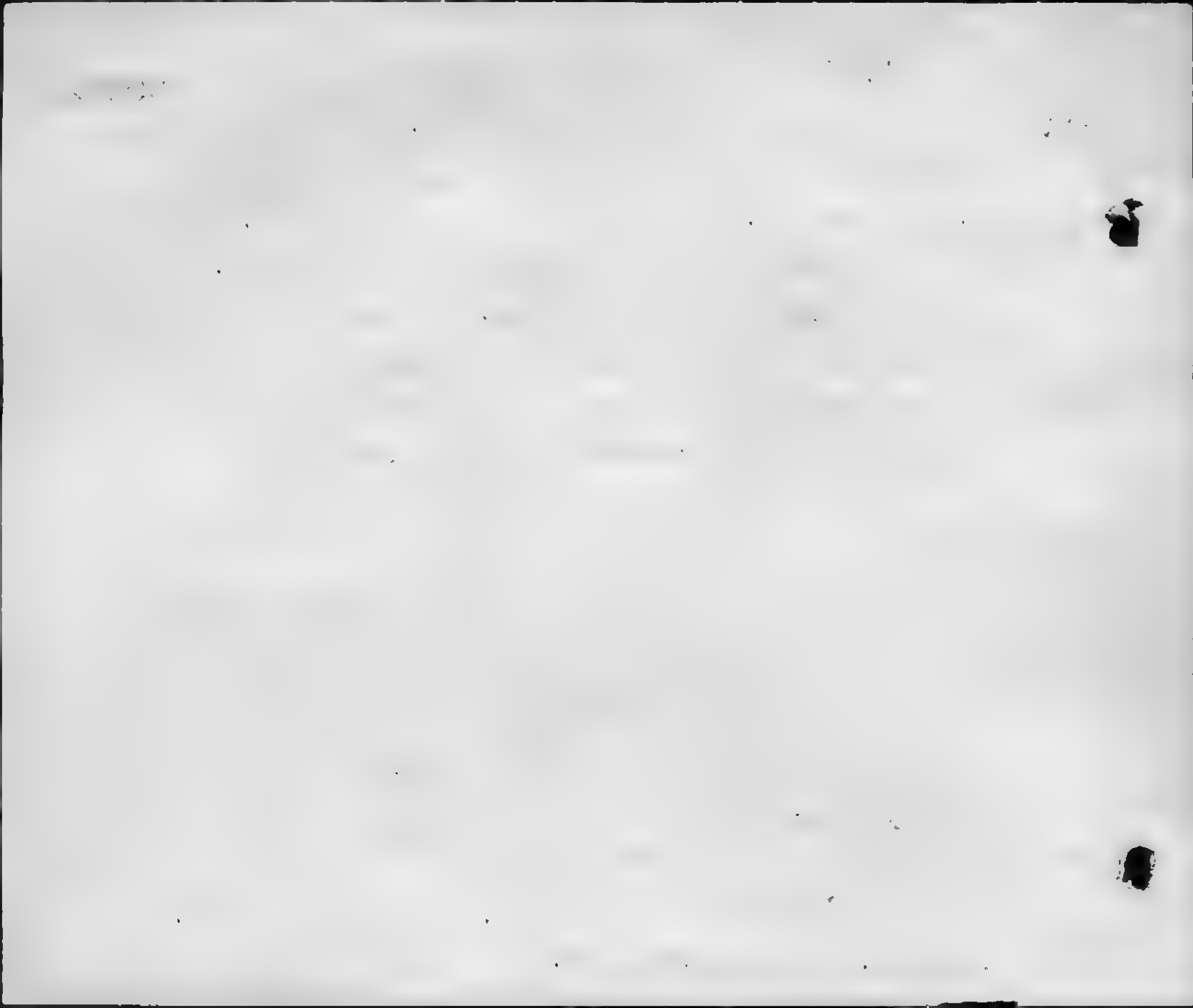
Item 14 Film G297 10/2/61 mh

09902

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1807 Taylor Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Rural and give nearest town; if institution, give name of institution) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>1807 Taylor Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Fritz</u> Last <u>Fritz</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1913</u>			
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Storm Windows</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jacob Fritz</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>218-03-6655</u>			
17. INFORMANT <u>Mrs Lillian Fritz</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>358.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/27, 1960</u> to <u>9/20, 1961</u>, that (I) (we) last saw the deceased alive on <u>9/19, 1961</u>, and that death occurred at <u>7:30 AM</u>, from the causes and on the date stated above.					
22a. SIGNATURE <u>Wm. F. Rehner</u>		22b. DATE SIGNED <u>SEP 22 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm. F. Rehner</u>		22d. ADDRESS <u>11 W. 29th St Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>9/23/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1961</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

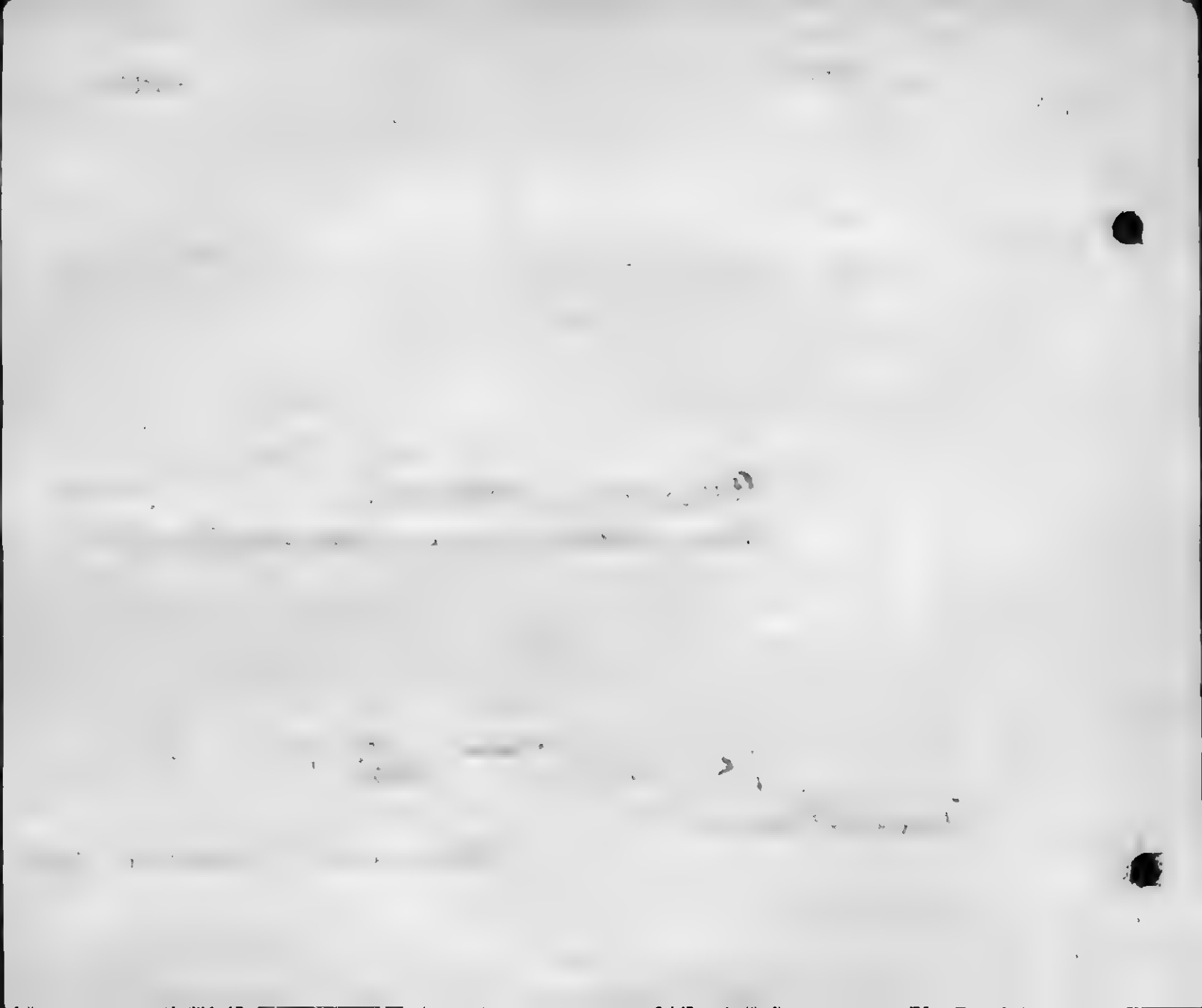
9912

09903

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>12 PAXSON AVE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12 PAXSON AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHATONSVILLE</u> d. STREET ADDRESS <u>12 PAXSON AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>MARGARET A. GAITHER</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>7</u> Year <u>1961</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/17/1881</u>		9. AGE (In years last birthday) <u>160</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>													
13. FATHER'S NAME <u>CHARLES BOBBIT</u>		14. MOTHER'S MAIDEN NAME <u>BARBER</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs Myrtle Ridgely</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4-5-1 DUE TO (b) <u>Cardio Vascular Disease & Compensatory</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>March 1959</u> to <u>9/7</u> 1961 , that (I) (we) last saw the deceased alive on <u>9/5</u> 19 <u>61</u> , and that death occurred <u>9/7</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Edna W. Johnson</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)									
22d. ADDRESS <u>3432 Frederick Ave Baltimore 9/7/61</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S</u>									
23d. LOCATION (City, town or county) <u>Howard Co. MD.</u>													
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Smith & Son - 28</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>									
DATE <u>SEP 13 '61</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

VR A15 (4)
 15M 9/60



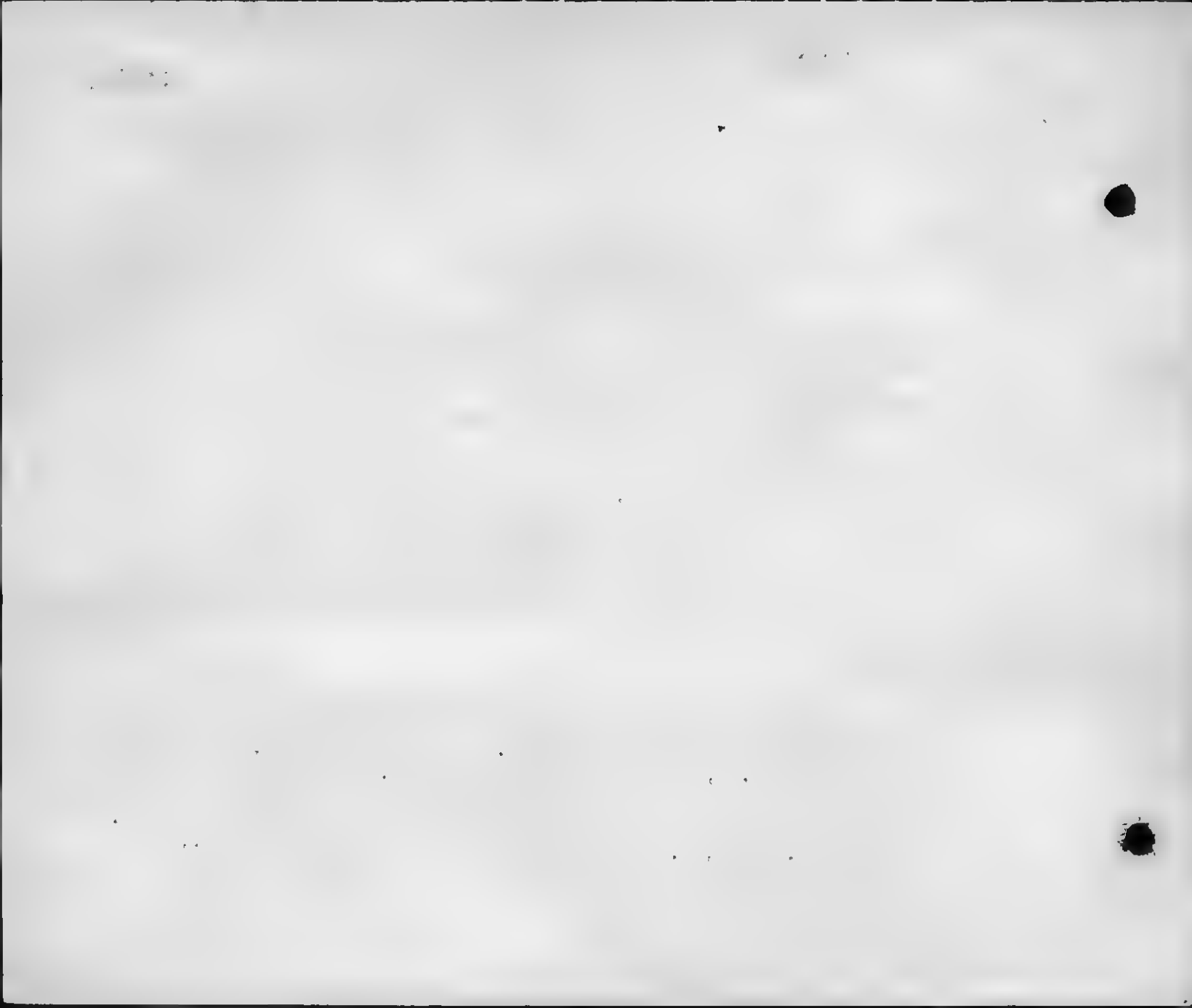
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

5 I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9913
CERTIFICATE OF DEATH

09904

1. PLACE OF DEATH a. COUNTY <u>Balto</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>648 Coleraine Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u> d. STREET ADDRESS <u>648 Coleraine Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred S. Galtton</u> First Middle Last 4. DATE OF DEATH <u>9/8/61</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 17, 1891</u> 9. AGE (in years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Pullman Ret.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Va.</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Galtton</u> 14. MOTHER'S MAIDEN NAME <u>Reip</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWI</u> 16. SOCIAL SECURITY NO. <u>000-00-0000</u> 17. INFORMANT <u>Mrs. Elizabeth R. Galtton</u> Address <u>1 Mallow Hill Ave., Baltimore 29, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, sigmoid colon</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>153.3</u> (c) <u>153.3</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>153.3</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>153.3</u> p.m. <u>153.3</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>153.3</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (M.D. or M.P.H.) attended the deceased from <u>Dec. 1951</u> to <u>Sept. 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 2, 1961</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leo J. Gaver, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>		22b. ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md.</u> 22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/11/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u> 23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u> 25a. REC'D BY REGISTRAR <u>SEP 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

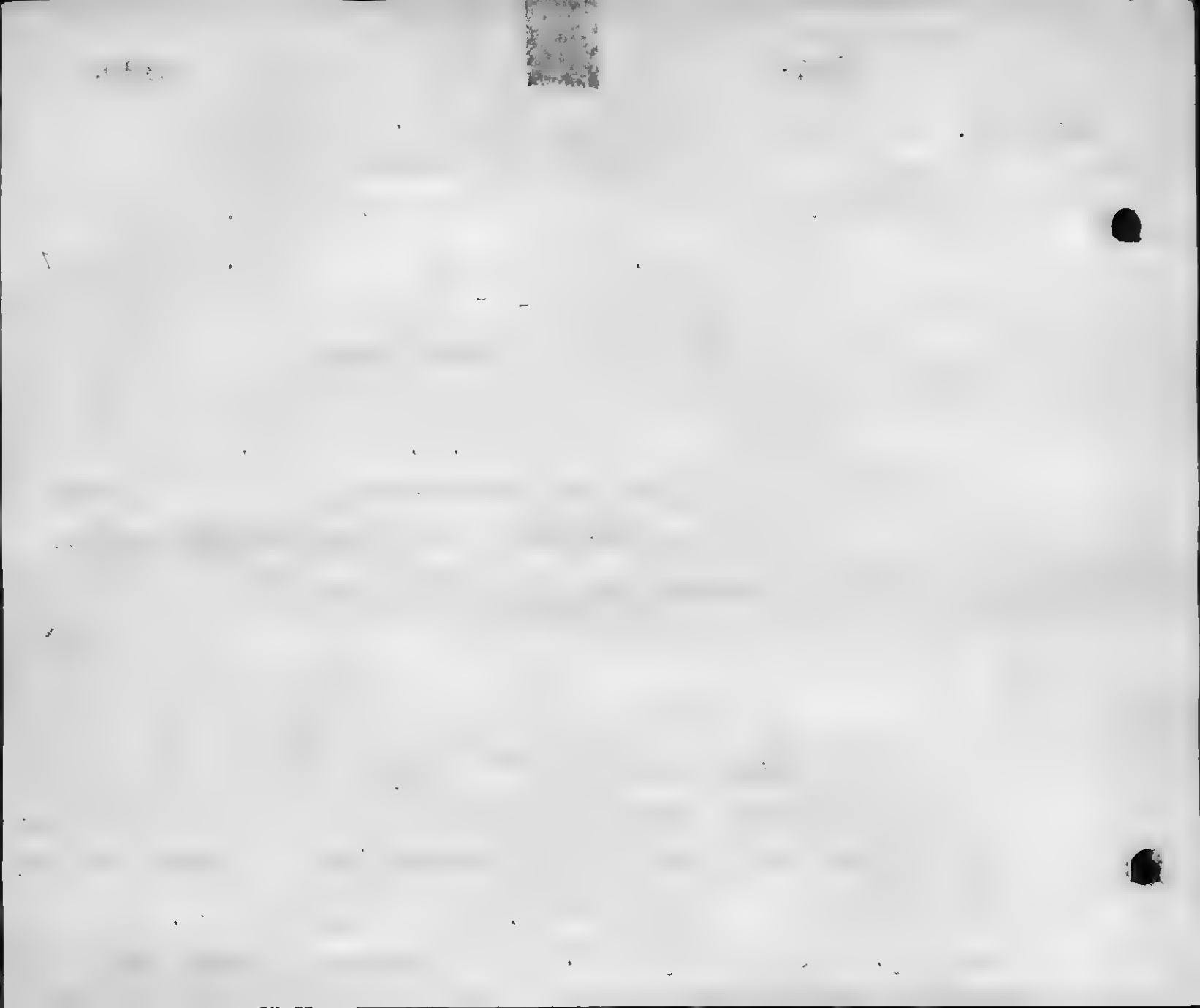


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MD
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9914
CERTIFICATE OF DEATH
09905

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holly Hill Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1216 Ramblewood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie C. Gettman</u> 4. DATE OF DEATH <u>Sept. 21, 1960</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-18-1887</u> 9. AGE (In years, last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min. IF UNDER 24 HRS. <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> 11. A. THE PLACE County & State, or foreign country <u>MARYLAND</u> 12. C. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Reckenberger</u> 14. MOTHER'S MAIDEN NAME <u>Catherine</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>George J. J. Gettman Jr. 7102 Hardman Rd.</u> 17. INFORMANT <u>George J. J. Gettman Jr. 7102 Hardman Rd.</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO (b) <u>Recurrent Carcinoma pelvic floor 4 yrs.</u> DUE TO (c) <u>primary in recto sigmoid</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 week</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>July 14, 1961</u> Hour <u>3:00</u> a.m. <u>3:00</u> p.m. 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1129 St Paul St Baltimore Md</u> 20f. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 14, 1961</u> to <u>Sept 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 20, 1961</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>S.G. Sullivan</u> 22b. DATE SIGNED <u>9-21-61</u> 22c. PHYSICIAN'S NAME (Type) <u>S.G. Sullivan</u> 22d. ADDRESS <u>1129 St Paul St Baltimore Md</u> 22e. REC'D BY REGISTRAR <u>Arthur S. Hanna</u> 22f. REGISTRAR'S SIGNATURE <u>SEP 25 '61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>9/23/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u> 23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Rd.</u> 25. DATE <u>SEP 25 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Per [redacted] may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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MARYLAND STATE DEPARTMENT OF HEALTH

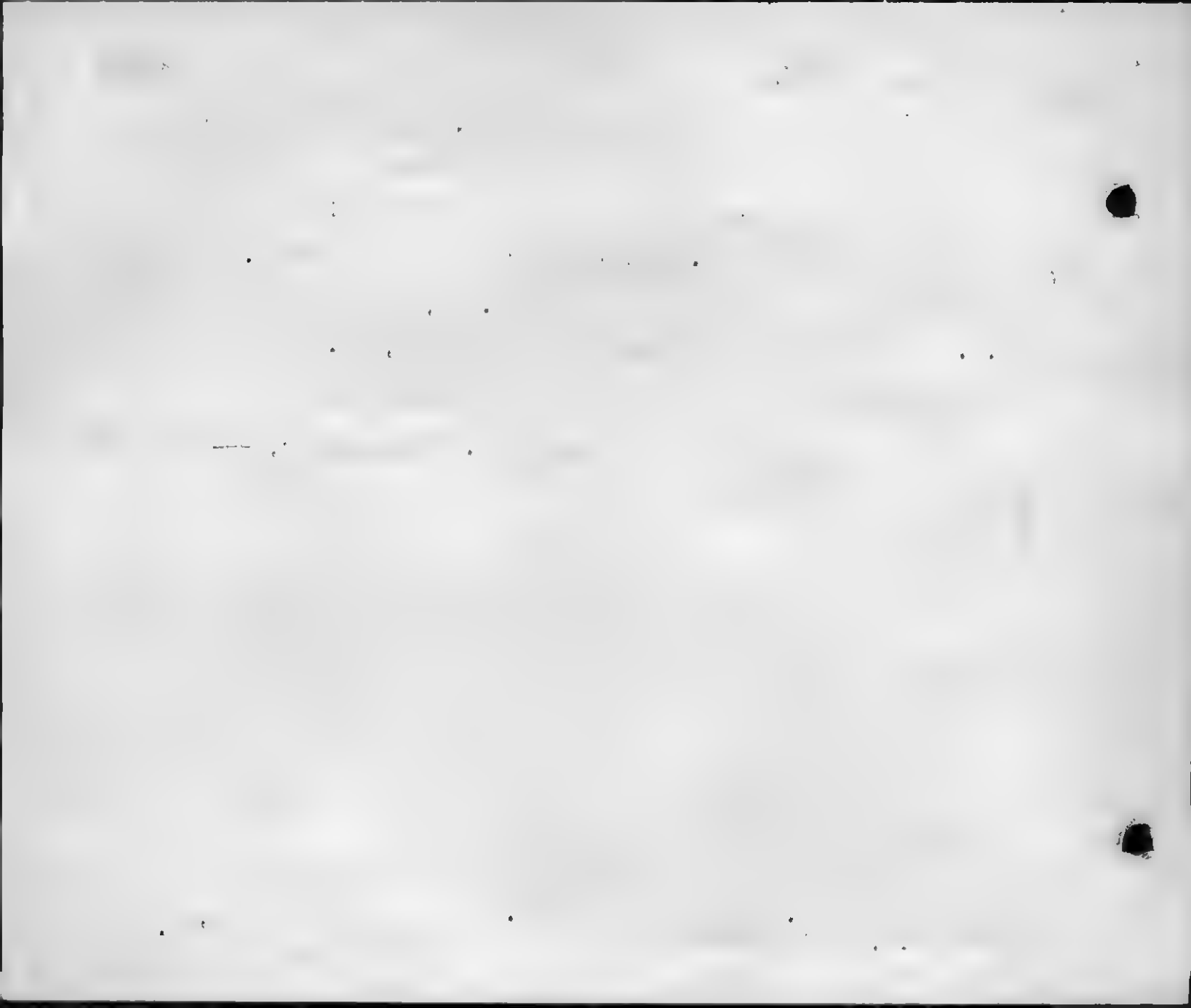
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9915

09906

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 2000 Oak Drive	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
c. LENGTH OF STAY IN 1b		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose M. Getzendanner		4. DATE OF DEATH Month Sept. Day 7 Year 61	
5. SEX Female		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1887	
9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 3 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE County & State, or foreign country Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gustaf Friede		14. MOTHER'S MAIDEN NAME Louise Neurshr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leroy T. Getzendanner, 2000 Oak Drive		Address Baltimore 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE - DUE TO PULMONARY EMBOLISM Conditions, if any, which gave rise to immediate cause (b) NO DUE TO NO cause last, (c) NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) NO		INTERVAL BETWEEN ONSET AND DEATH NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/1 19 61 to 9/7 19 61 , that (I) (we) last saw the deceased alive on 9/7 19 61 , and that death occurred at 5:30 from the causes and on the date stated above.			
22a. SIGNATURE John H. Surina		22b. DATE SIGNED 9/9/61	
22c. PHYSICIAN'S NAME (Type) John H. Surina		22d. ADDRESS 5800 EDMONDSON AVE. BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 11/61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk.		23d. LOCATION (City, town or county) (State) Baltimore 7, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Nitzke F.D.		24b. ADDRESS 4101 Edmondson Ave	
25a. REC'D BY REGISTRAR SEP 11 '61		25b. REGISTRAR'S SIGNATURE Charles E. House	



MARYLAND STATE DEPARTMENT OF HEALTH

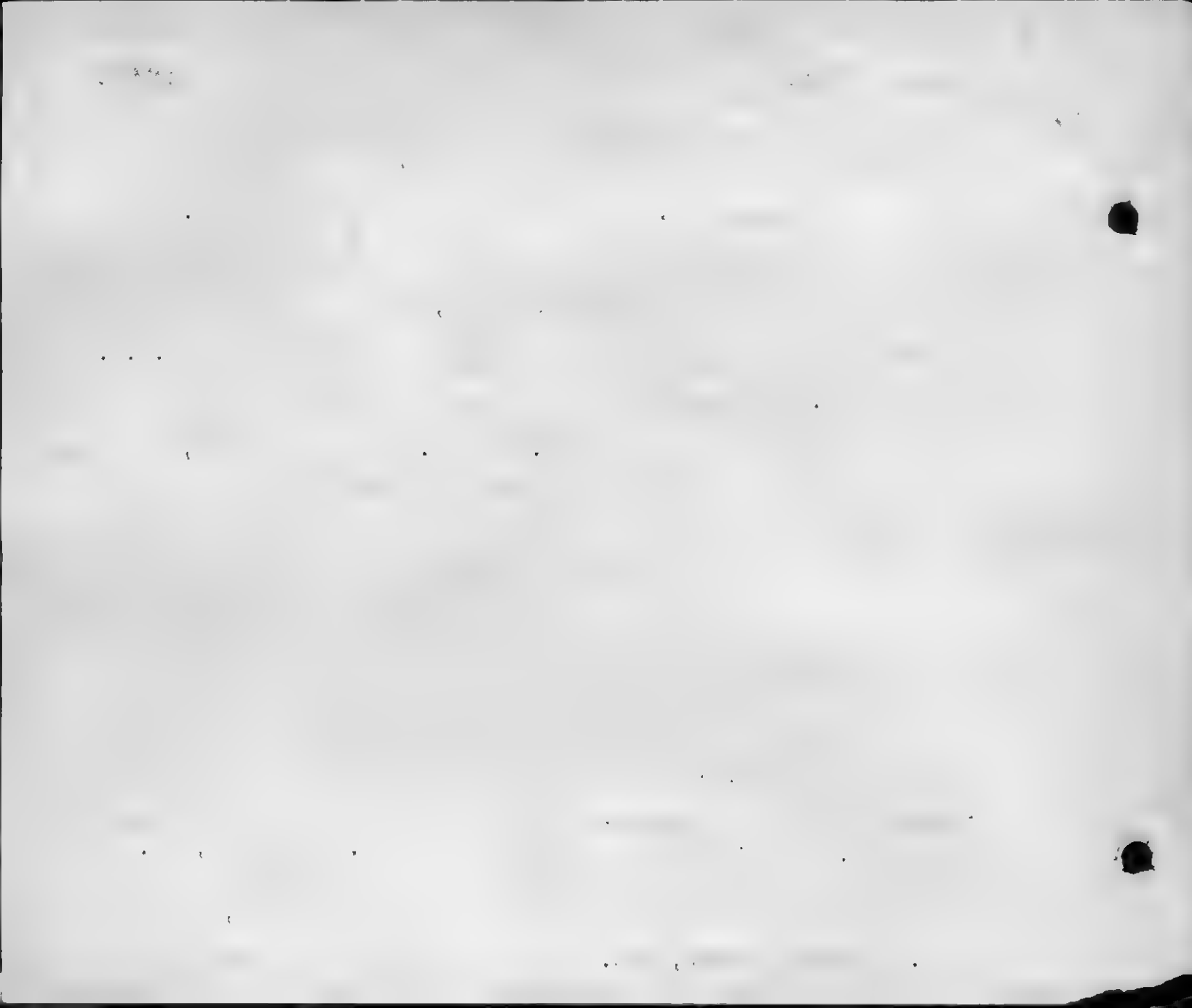
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09907

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Valley & Garrison Rds.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> d. STREET ADDRESS <u>Garrison & Valley Rds.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Eleanor Johnston Gibson</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>7</u> Year <u>1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>June 30, 1880</u>		9. AGE (In years last birthday) <u>81</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>							
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Bartlett S. Johnston</u>									
14. MOTHER'S MAIDEN NAME <u>Caroline Brooks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>									
16. SOCIAL SECURITY NO. Address <u>Mr. Jack S. Ewing Garrison, Maryland</u>		17. INFORMANT <u>Mr. Jack S. Ewing Garrison, Maryland</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO (b) <u>Intestinal tumor (malignant?)</u> DUE TO (c) <u>gail arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 10, 1949</u> to <u>Sept 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 7, 1961</u> and that death occurred at <u>12 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Palmer R. Williams</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Palmer Williams</u> 22d. ADDRESS <u>Linson Rd., Garrison, Md.</u> 22b. DATE SIGNED <u>Sept 9, 61</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>							
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc.</u> <u>1900 Eutaw Place</u>									
25a. REC'D BY REGISTRAR DATE <u>SEP 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Christina S. Finner</u>									

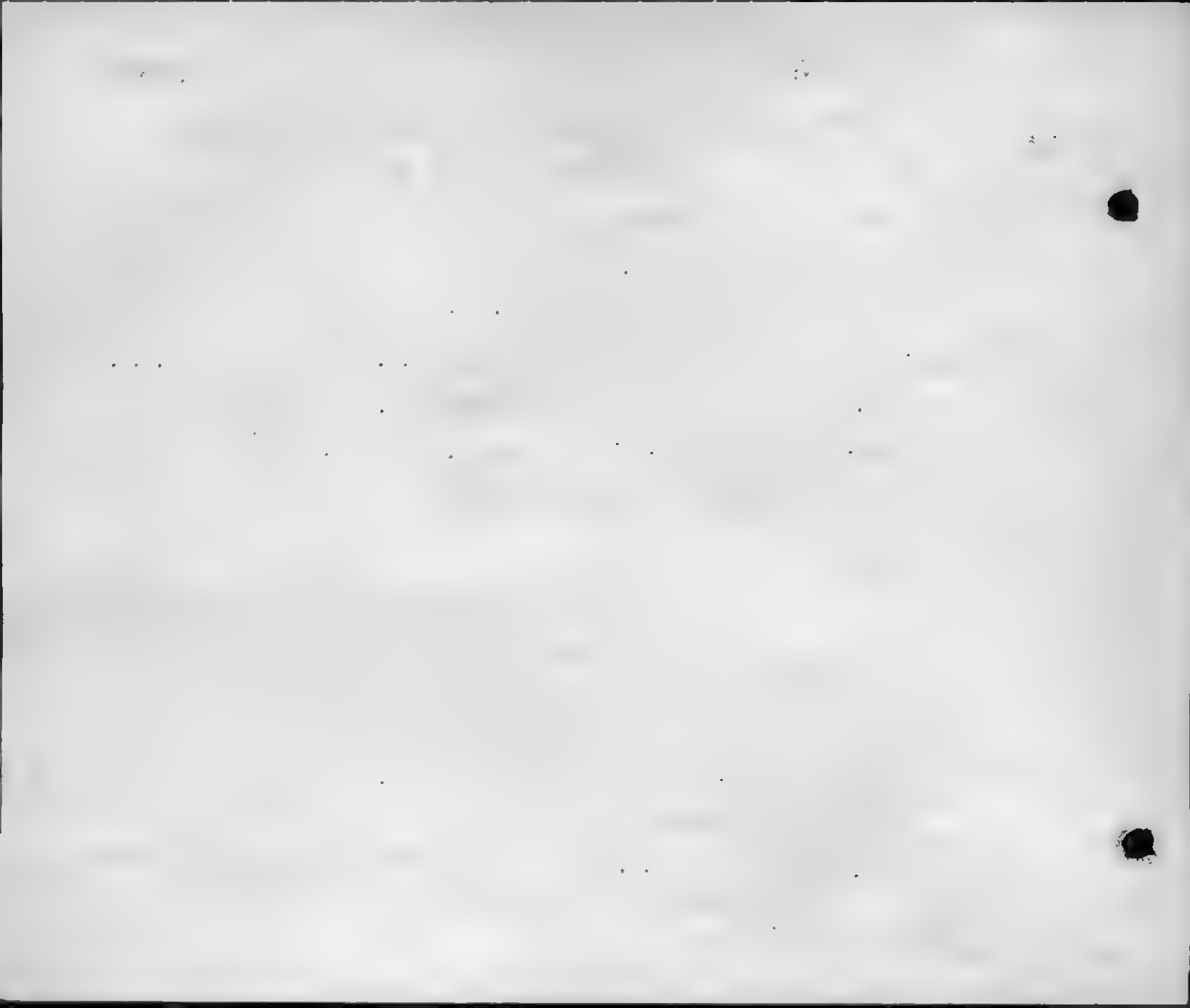
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9917											
09908											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <u>Maryland</u> <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS <u>Main Street</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> <u>107 days</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CLIFFORD E. GODLEY</u>						4. DATE OF DEATH <u>September 8, 1961</u>					
5. SEX <u>Male</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Oct. 22, 1893</u>					
9. AGE (In years last birthday) <u>67</u> yrs.						10. IF UNDER 1 YEAR: Months <u>14</u> Days <u>X</u> Hours <u>-</u> Min. <u>-</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Television-Radio</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Newark, N.J.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Clifford R. Godley</u>						14. MOTHER'S MAIDEN NAME <u>Caroline J. Van Houghton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-1</u>						16. SOCIAL SECURITY NO <u>221-05-6913</u>					
17. INFORMANT <u>Baltimore, Maryland - FORT HOWARD DIVISION</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYELOGENOUS LEUKEMIA</u> DUE TO (b) <u>UNKNOWN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>UNKNOWN</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>1</u> p.m. <u>35</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that <u>U</u> (this hospital) attended the deceased from <u>May 24, 1961</u> to <u>Sept. 8, 1961</u> , that <u>we</u> (we) last saw the deceased alive on <u>Sept. 8, 1961</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John D. Talbert</u> M.D.						22b. DATE SIGNED <u>9-9-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>John D. Talbert</u> M.D.						22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Sept. 11/61</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL CEMETERY</u>						23d. LOCATION (City, town or county) (State) <u>ROCK HALL MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin Williams</u> ADDRESS <u>Chestertown Md</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 13 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Clifford S. Kline</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9918					09909				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Baltimore</u>					a. STATE <u>Maryland</u>				
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>					b. COUNTY <u>3 VC 1-4</u>				
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>					c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>					d. STREET ADDRESS <u>743 E. Preston Street</u>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <u>Jonathan</u> <u>Melvin</u> <u>GORDON</u>					Year Month Day <u>9</u> <u>20</u> <u>19 61</u>				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>Negro</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>8/18/52</u>				
9. AGE (In years last birthday) <u>9</u> yrs.					10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Melvin Gordon</u>					14. MOTHER'S MAIDEN NAME <u>Hazel Carpenter</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>---</u>				
17. INFORMANT <u>Rosewood Records, Owings Mills, Md.</u>					Address <u>---</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial pressure</u>					<u>7 yrs.</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tumor 3rd ventricle; etiology undetermined</u>					<u>8 yrs.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>58</u> to <u>9/20</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/20/</u> , 19 <u>61</u> , and that death occurred at <u>3:15 p.m.</u> the causes and on the date stated above.									
22a. SIGNATURE <u>Harry G. Butler</u>					22b. DATE SIGNED <u>9/21/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>					22d. ADDRESS <u>Rosewood State Training School</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>9/23/61</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Balt. Nat. Cem.</u>					23d. LOCATION (City, town or county) (State) <u>Balt. Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Milton E. Elchman</u>					25a. REC'D BY REGISTRAR <u>SEP 22 '61</u>				
ADDRESS <u>1129 N. Caroline St.</u>					25b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>				

[Faint handwritten notes at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

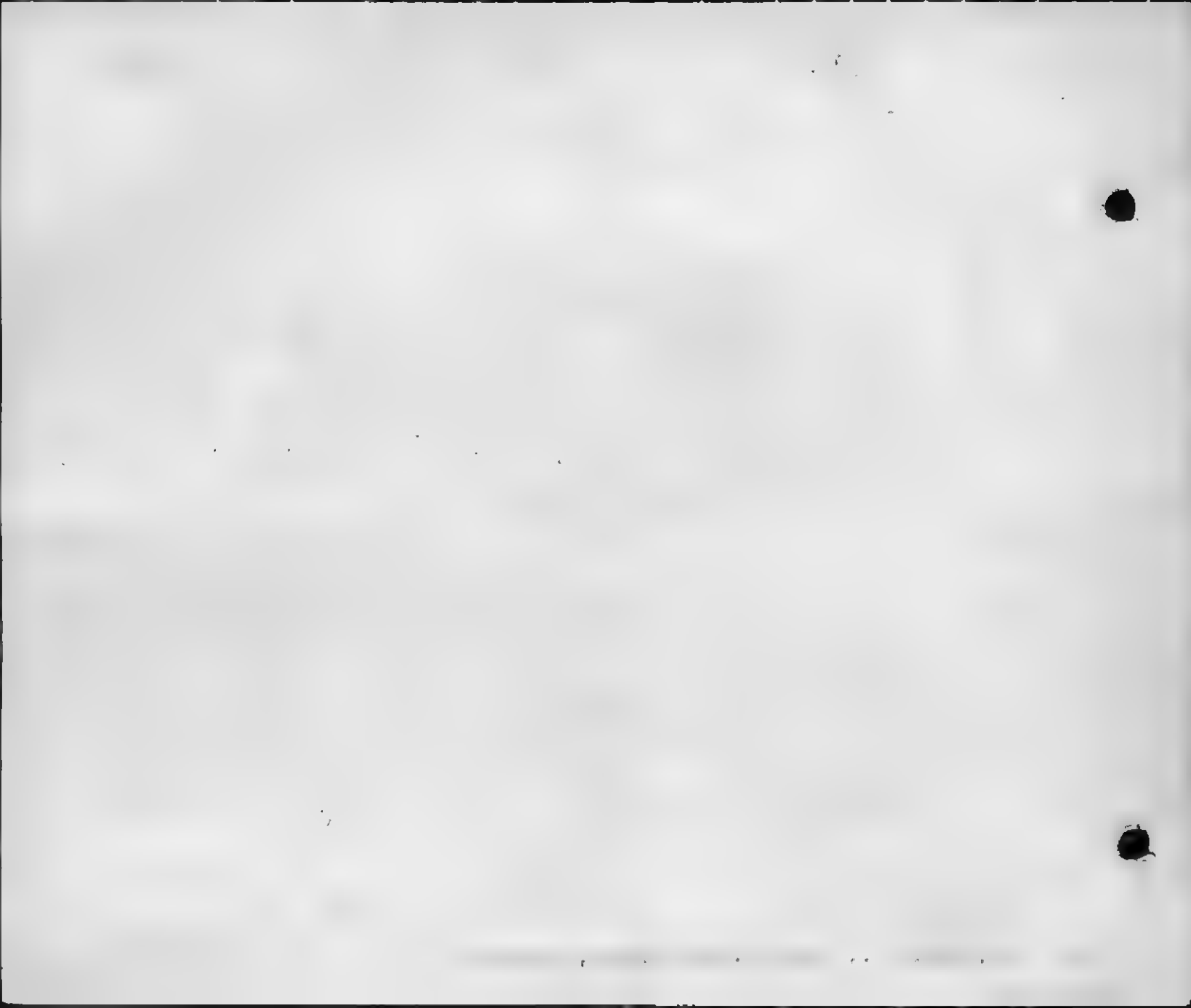
VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9919 CERTIFICATE OF DEATH 09910											
1. PLACE OF DEATH a. COUNTY BALTIMORE						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE						c. LENGTH OF STAY IN lb 13 1/2 YEARS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MASONIC HOME						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE					
d. STREET ADDRESS 4509 ARABIA AVE						b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH GORSUCH						4. DATE OF DEATH Month Day Year SEPT 15 1961					
5. SEX FE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME GEORGE W. AWALT						14. MOTHER'S MAIDEN NAME CAROLINE PFEIFFER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO. 214-26-4791		17. INFORMANT Address Frank L. Smith Jr., Cockeysville Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute's Subacute Cardis 42 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 13 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTIMORE		20g. (County) BALTIMORE		20h. (State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 6-21-1946 to 9-15-1961 ; that (I) (we) last saw the deceased alive on 9-15-1961 , and that death occurred at 5:20 PM , from the causes and on the date stated above.											
22a. SIGNATURE Walter T. Kees						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/15/61			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES						22d. ADDRESS COCKEYSVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-18-61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) Baltimore		23e. (State) MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore						ADDRESS 1217 St. Paul Street, Baltimore		25a. REC'D BY REGISTRAR SEP 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krasner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
8920 CERTIFICATE OF DEATH 09914															
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>300 S. Stricker Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>RAYMOND E. GREEN</u>				4. DATE OF DEATH <u>September 2 19 61</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August 16, 1926</u> 9. AGE (in years last birthday) <u>35</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal Factory</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Raymond Green</u>				14. MOTHER'S MAIDEN NAME <u>Grace Meyers</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give order dates of service) <u>Yes WWII</u>				16. SOCIAL SECURITY NO. <u>217-20-0607</u>			
17. INFORMANT <u>Clinical Records, VAH, BALTIMORE, MD.</u>				18. CAUSE OF DEATH [Enter on Y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LACIENEC'S CIRRHOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESOPHAGEAL VARICES</u> (c) <u>GASTRIC HEMORRHAGE DUE TO (B)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>UNKNOWN</u>							
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>TERMINAL BRONCHOPNEUMONIA</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>12:30AM</u> p.m. <u>_____</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VAH, BALTIMORE, MD. - FT HOWARD DIVISION</u>							
20f. (City or town) <u>Baltimore</u>				20g. (County) <u>Baltimore</u>				20h. (State) <u>Md</u>							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 11</u> .., 19 <u>61</u> , to <u>September 2, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 2 19.61.</u> , and that death occurred <u>12:30AM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>ERNEST C. BROWN, M.D.</u>				22b. DATE SIGNED <u>9/2/61</u>											
22c. PHYSICIAN'S NAME (Type) <u>ERNEST C. BROWN, M.D.</u>				22d. ADDRESS <u>VAH, BALTIMORE, MD. - FT HOWARD DIVISION</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>9-6-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>							
23d. LOCATION (City, town or county) <u>BALTIMORE 28, MARYLAND</u>				23e. REC'D BY REGISTRAR <u>SEP 6 '61</u>				23f. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Blight Funeral Home, 6009 Harford Rd. Baltimore, Md.</u>															



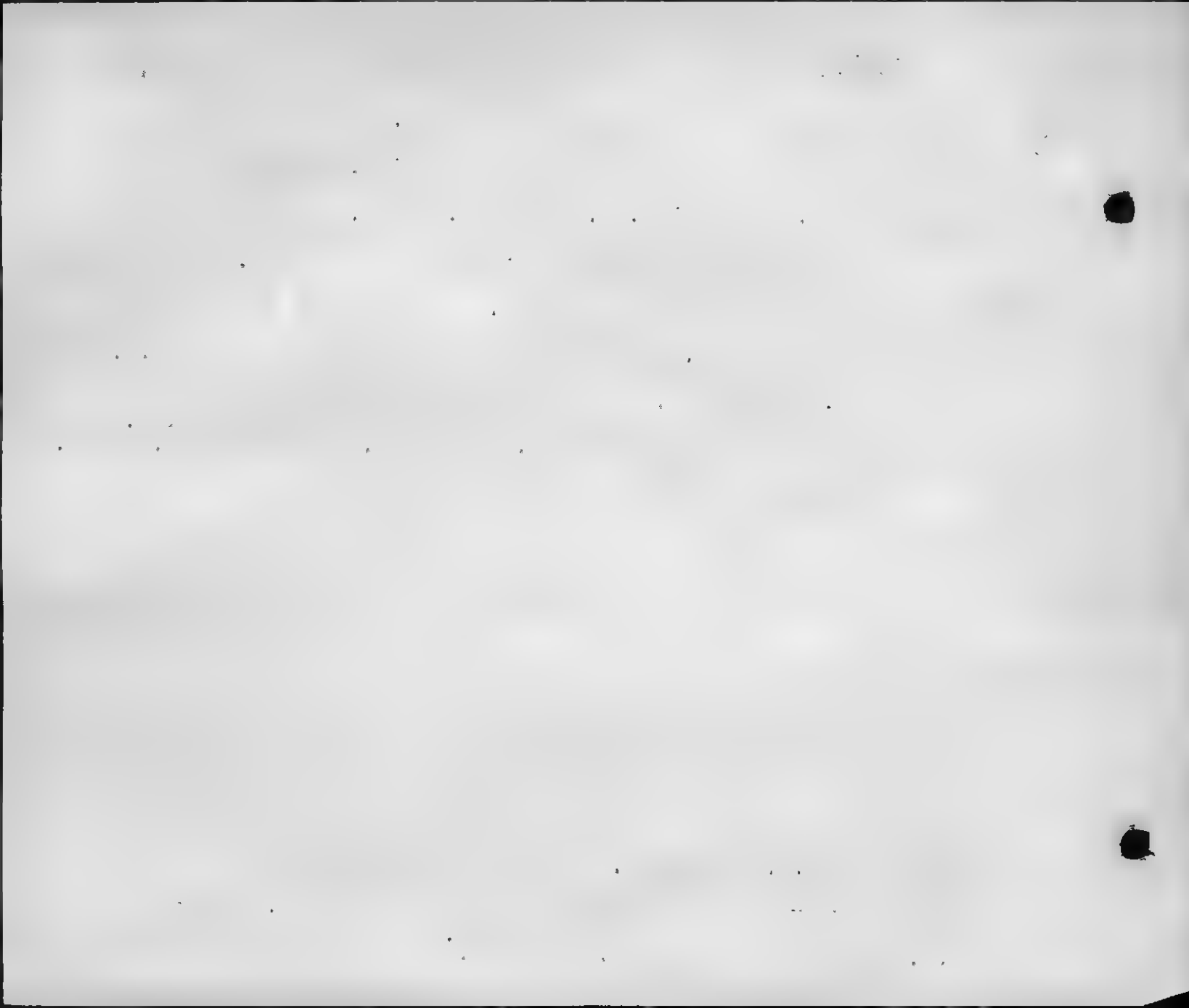
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09912									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Court Road, Pikesville, Md.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland d. STREET ADDRESS 228 E. 3rd St.				
3. NAME OF DECEASED (Type or print) David Arnold Hardman					4. DATE OF DEATH Sept. 19, 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH Feb. 22, 1938				
9. AGE (In years last birthday) 23					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector					10b. KIND OF BUSINESS OR INDUSTRY Md. State Roads				
11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME David N. Hardman, Jr.					14. MOTHER'S MAIDEN NAME Cordell Crommell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 218-34-4025				
17. INFORMANT Frederick, Md.					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) None				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				
20a. TIME OF INJURY 9:15 p.m.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran over by bulldozer				
20c. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/>					20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick, Md.				
20e. (City or town) Pikesville, Balt. Md.					20f. (County) Frederick				
20g. (State) Md.					21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
22. ACTUAL SIGNATURE D. D. Caples, M.D.					23. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
24. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					25. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
26. DATE SIGNED 9-19-61					27. ADDRESS (Street, city, town, or county) Frederick, Md.				
28. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					29. 22b. DATE THEREOF 9-22-61				
30. 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery					31. 22d. LOCATION (City, town, or country) Frederick, Maryland				
32. 23. FUNERAL DIRECTOR M.R. Etchinson, & Son, 106 E. Church St.					33. 24e. REC'D BY REGISTRAR SEP 22 '61				
34. 24b. REGISTRAR'S SIGNATURE Charles L. Kraus									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9922

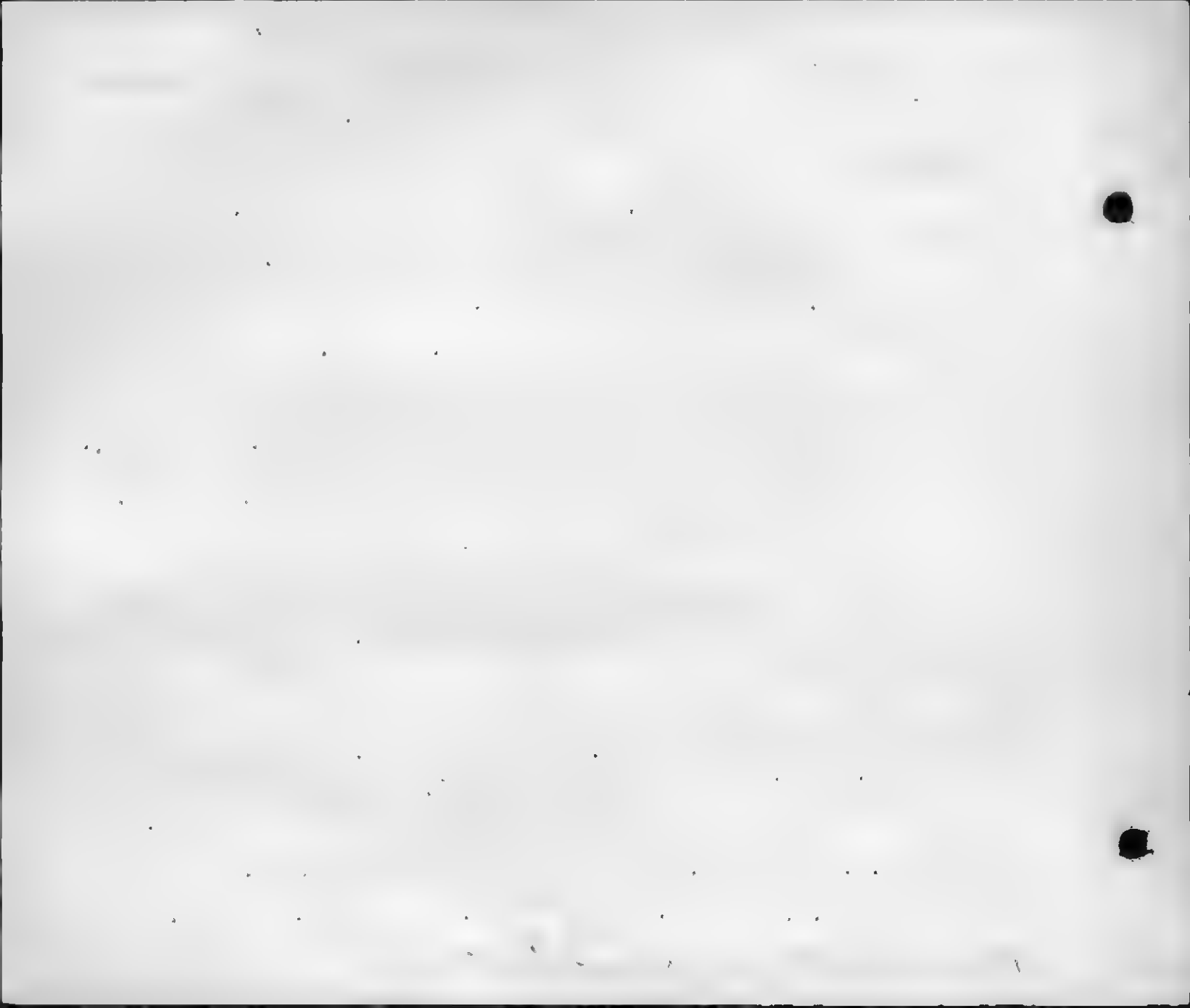
9913

1. PLACE OF DEATH a. COUNTY Howard Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethrope		c. LENGTH OF STAY IN 1b X Halethrope	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2011 Northeast Ave.		d. STREET ADDRESS 12011 Northeast Ave.	
3. NAME OF DECEASED (Type or print) SARAH HARDMAN		4. DATE OF DEATH Month SEPT. Day 28, Year 1961	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1950
9. AGE (In years last birthday) 11 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alex Boyer		14. MOTHER'S MAIDEN NAME Mary Kent	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel Malachi		Address 616 N. Payson St..	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3yrs 8Mo. 16 Days.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 18th, 1958 to Sept. 28th, 1961 , that I last saw the deceased alive on Sept. 28th, 1961 , and that death occurred at 4:10 A.M. M, from the causes and on the date stated above			
ACTUAL SIGNATURE C. F. Maloney, M.D.		ADDRESS (Street, city or town, state) 57 Winters Lane Catonsville 28. Md.	
DATE SIGNED Sept. 28-61			
PHYSICIAN'S NAME (Type) C. F. Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 2, 1961	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams		ADDRESS 322 N. Schroeder St.	
24a. REC'D BY REGISTRAR Oct 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it must be executed by the Deputy Medical Examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9923

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

99914

1. PLACE OF DEATH a. COUNTY <u>Sparks-Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence must be admitted on) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5900 Glenkirk Road</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> c. LENGTH OF STAY IN b <u>Diecraft Factory- York Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Diecraft Factory- York Road</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1961</u>	
3. NAME OF DECEASED (Type or print) <u>Vernon M. Hart Sr.</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years, if under 1 year, if under 24 hrs. last birthday) <u>53</u> yrs.		9. AGE (In years, if under 1 year, if under 24 hrs. last birthday) <u>53</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pinkerton</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William S. Hart</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gibbons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>215-03-4222</u>	
17. INFORMANT <u>Mrs. Lillian B. Hart Sr.</u>		Address <u>5900 Glenkirk Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		DATE SIGNED <u>9/18/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Wm. J. Schmitt & Sons</u>		24a. REC'D BY REGISTRAR <u>SEP 20 '61</u>	
ADDRESS <u>Baltimore 13, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

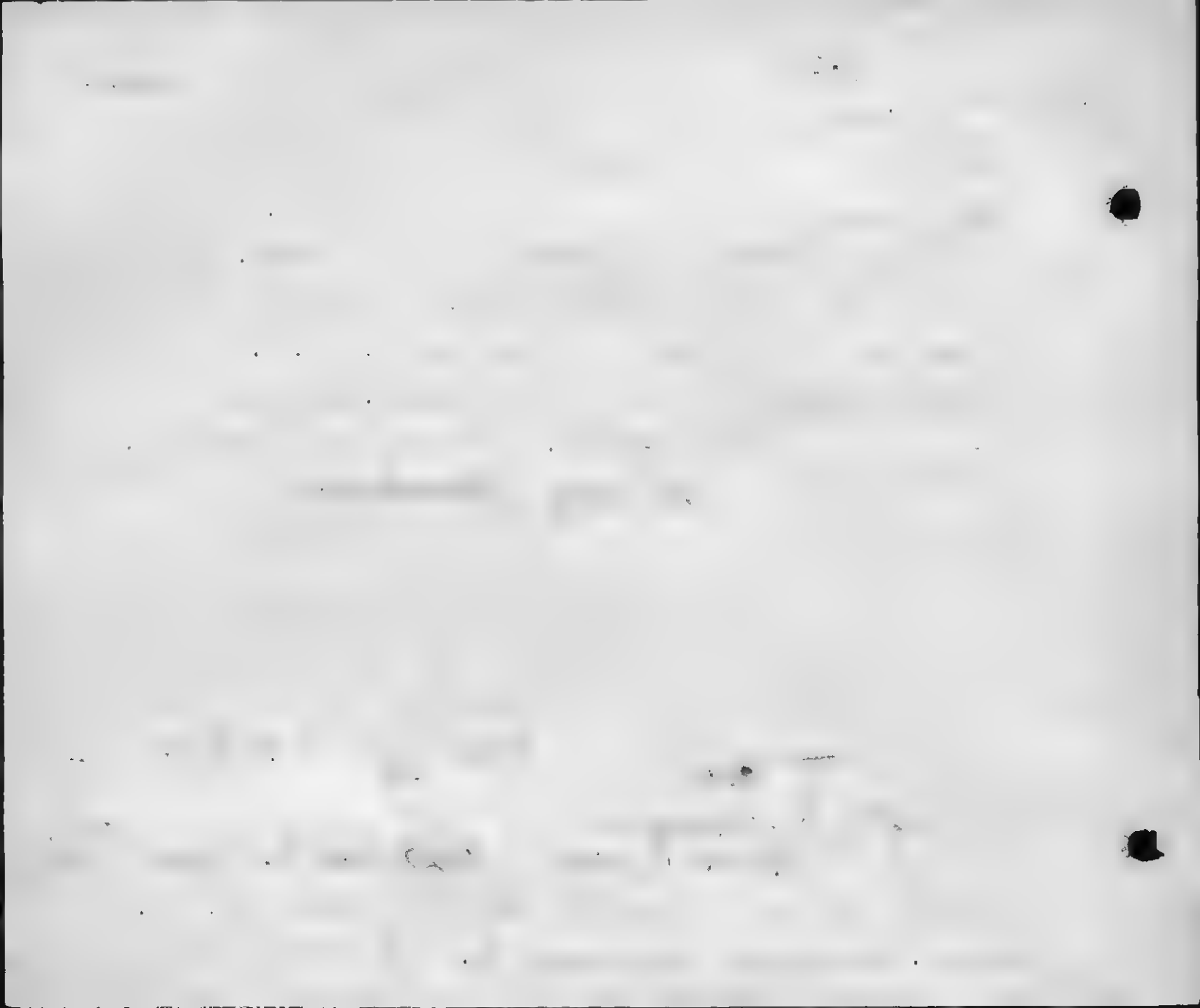
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9924

09915

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) e. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN b. 3 days		d. STREET ADDRESS 233 Taylor Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1925 York Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Matilda Hatswell		4. DATE OF DEATH Sept. 20 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 21 Days 03 Hours 02 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walter Daniels		14. MOTHER'S MAIDEN NAME Emma M. Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-30-0241	
17. INFORMANT G. Robert Lyles Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 9		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-20-1961 , to 9-20-1961 , that (I) (we) last saw the deceased alive on 9/20/1961 , and that death occurred at 5:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE M. X. Quinn		22b. DATE SIGNED 9/20/61	
22c. PHYSICIAN'S NAME (Type) M. KEVIN QUINN		22d. ADDRESS 1927 YORK RD, TIMONIUM MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR SEP 22 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

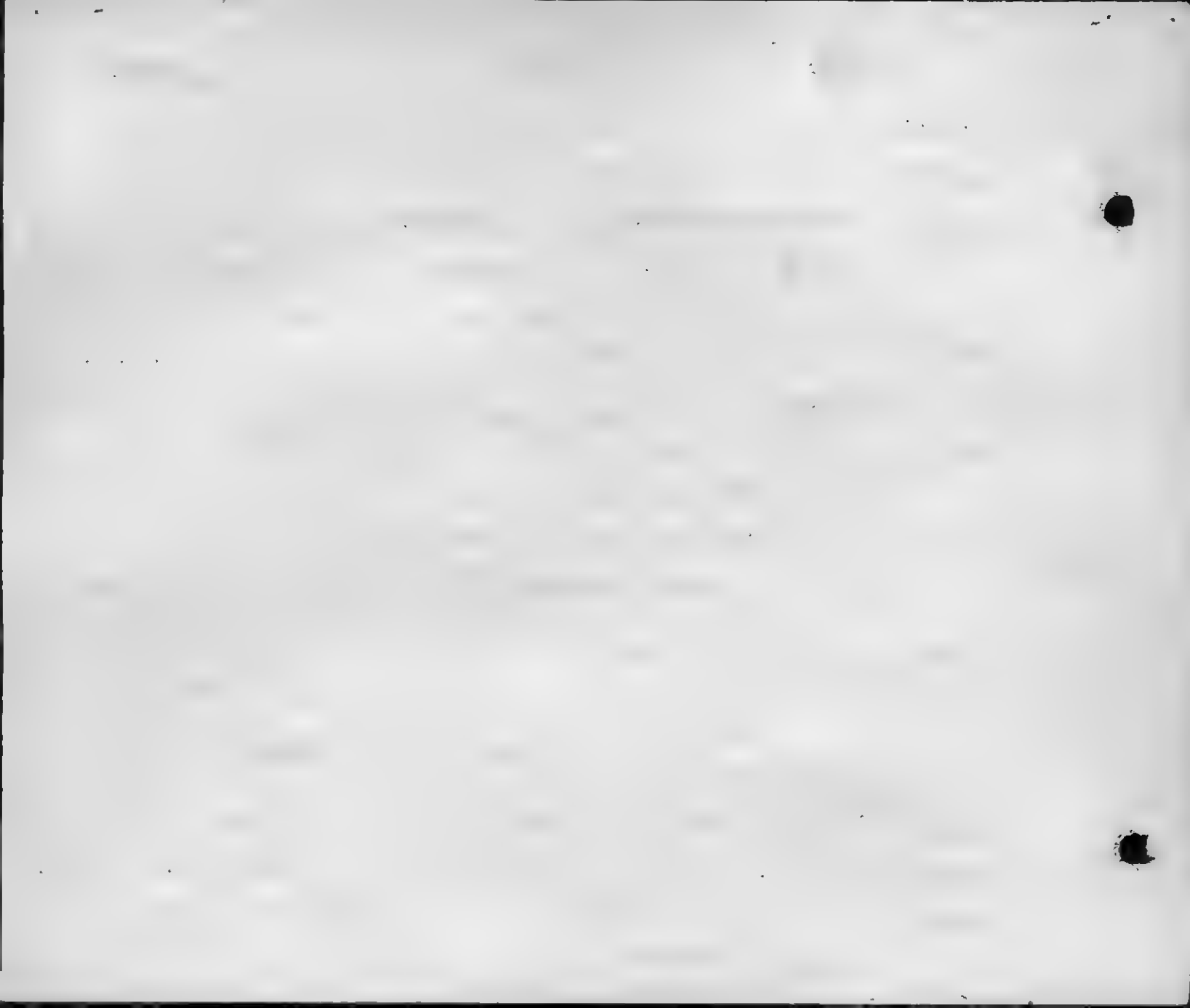
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9925

09916

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>23 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2714 Gray Manor Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>February 7, 1898</u> 9. AGE (In years, last birthday) <u>63</u> yrs. 10. MONTH <u>September</u> 11. DAY <u>21</u> 12. HOUR <u>19</u> 13. MIN. <u>61</u>		4. DATE OF DEATH <u>September 21, 1961</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Asphalt Company</u> 13. FATHER'S NAME <u>George W. Heisterman</u> 14. MOTHER'S MAIDEN NAME <u>Linda Russell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u> 16. SOCIAL SECURITY NO. <u>215-07-9887</u> 17. ADDRESS <u>Clinical Records, VAH, Baltimore 18, Maryland</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RHEUMATIC HEART DISEASE</u> (b) <u>BILATERAL PULMONARY ATELECTASIS</u> (c) <u>BILATERAL HYDROTHORAX</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>UNKNOWN</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>3:00</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (X (this hospital) attended the deceased from <u>August 29, 1961</u> to <u>September 21, 1961</u> that (X (we) last saw the deceased alive on <u>September 21, 1961</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Sebastian Russo M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-25-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore 28, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14</u> 25a. REC'D BY REGISTRAR <u>SEP 26 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraw</u> 25c. DATE <u>9/21/61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

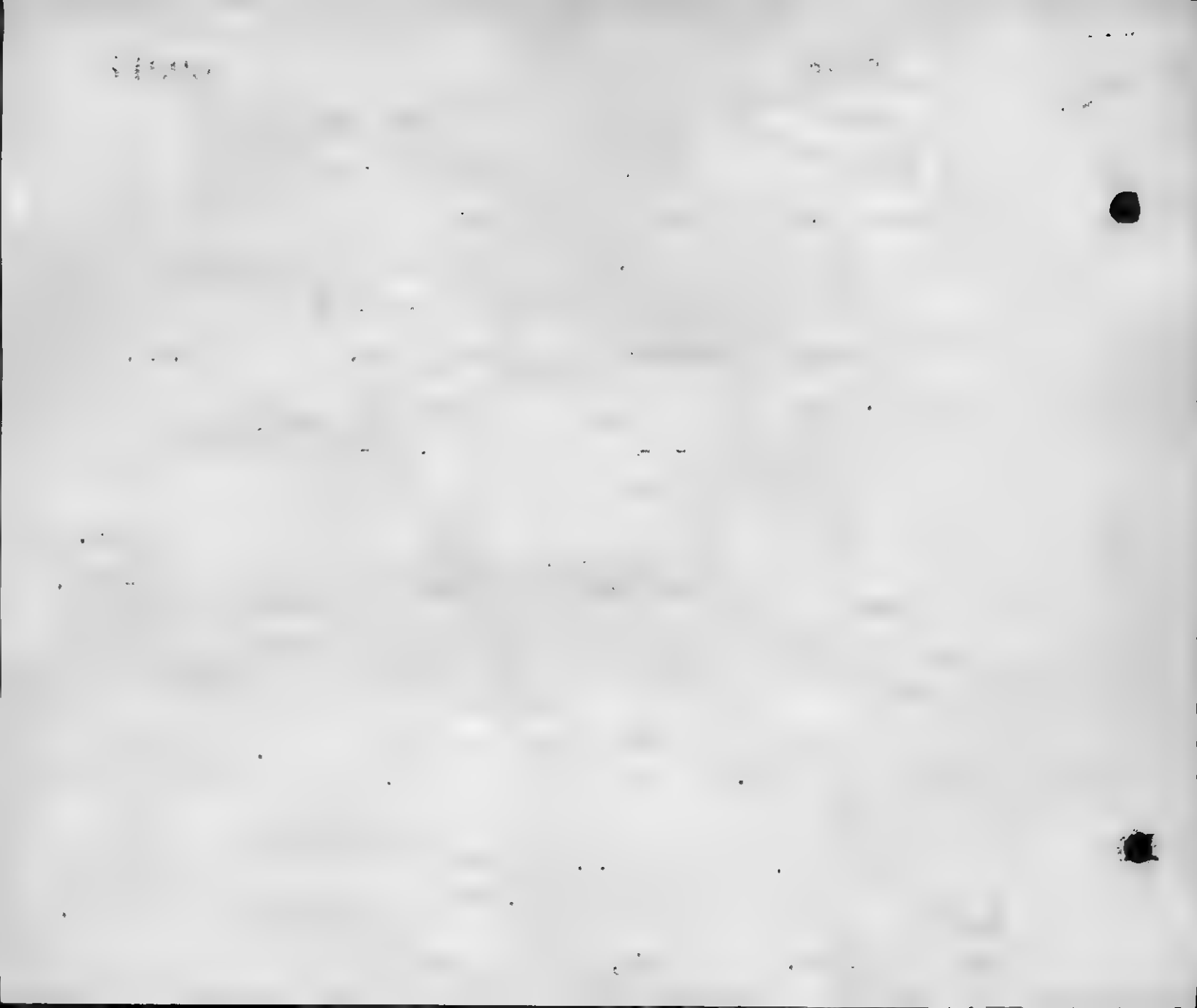
CERTIFICATE OF DEATH

9926

09917

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b. <u>52 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 14</u> d. STREET ADDRESS <u>2619 Moore Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>GERALD P. HESS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>19 61</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>									
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 10, 1918</u>									
9. AGE (In years last birthday) <u>42</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bull Dozer Operator</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
11. BIRTHPLACE (Country & State, or foreign country) <u>Saluvia, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>George R. Hess</u>		14. MOTHER'S MAIDEN NAME <u>Viole Sipe</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW-11</u>		16. SOCIAL SECURITY NO. <u>204-03-2979</u>									
17. INFORMANT <u>Clinical Records, VA Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> (b) <u>UREMIA</u> (c) <u>ARTERIOSCLEROSIS</u> (Kimmelstiel-Wilson Disease)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u> <u>2 yrs.</u> <u>2-3 yrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year: Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 9, 1961</u> to <u>Sept. 30, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 30, 1961</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>WALTER J. PIJANOWSKI, M.D.</u>		22b. DATE SIGNED <u>Sept. 30, 1961</u>									
22c. PHYSICIAN'S NAME (Type) <u>WALTER J. PIJANOWSKI, M.D.</u>		22d. ADDRESS <u>VAH, Baltimore 18, Maryland</u> <u>Fort Howard Division</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/3/61</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Siding Hill Chr. Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Harrisonville Penna.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sander & Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>OCT 3 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. ADDRESS <u>North Ave. & Broadway Baltimore, Maryland</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

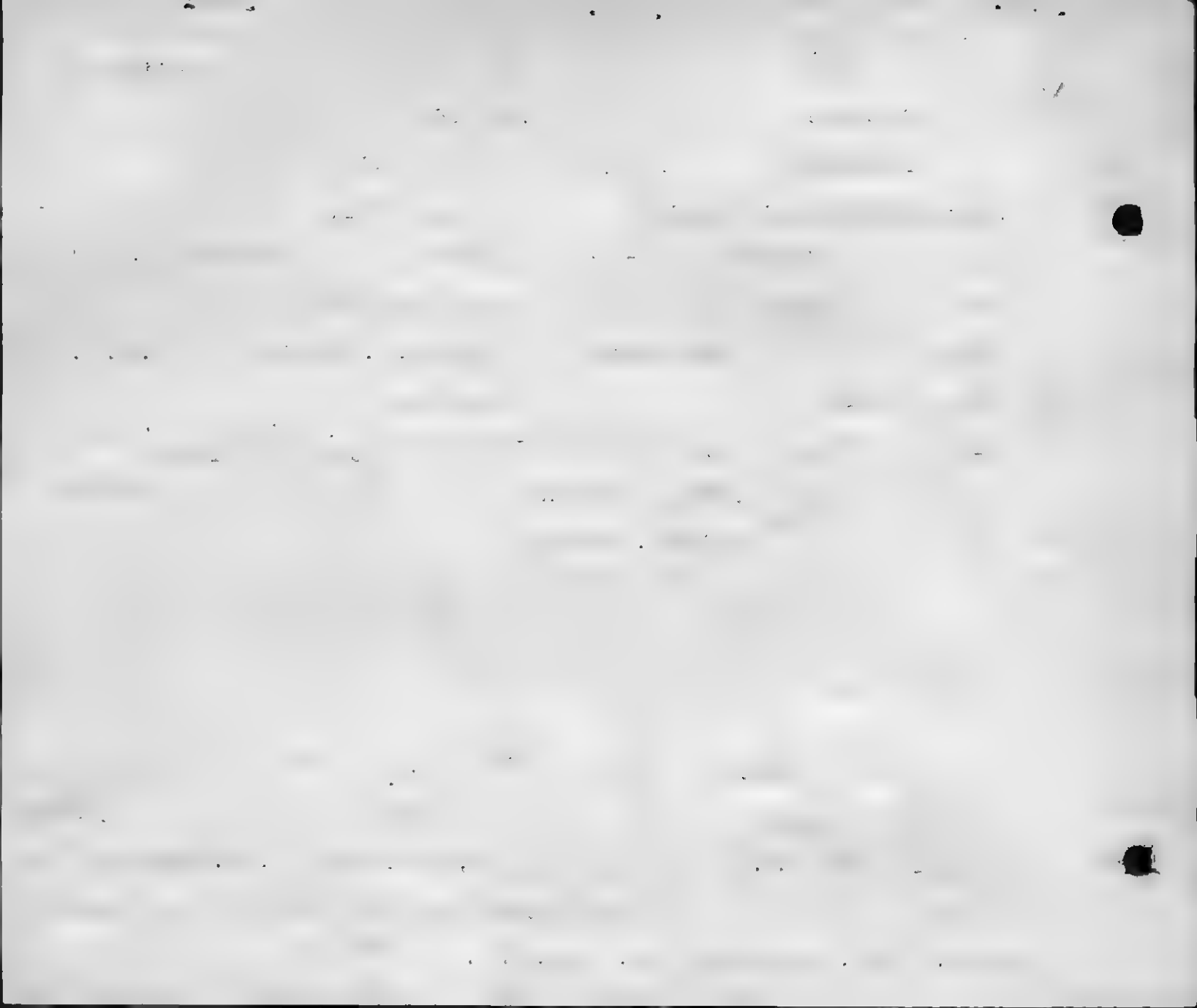


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
9927		09918	
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		d. STREET ADDRESS 304 Wheeler Court	
c. LENGTH OF STAY IN 1b 10 Days		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		f. DATE OF DEATH September 10 19 61	
3. NAME OF DECEASED (Type or print) BENJAMIN		g. DATE OF DEATH September 10 19 61	
5. SEX Male		8. DATE OF BIRTH October 24, 1920 40	
6. COLOR OR RACE Negro		9. AGE (In years last birthday) 40 YES <input type="checkbox"/> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Company	
13. FATHER'S NAME Julius Heyward		11. BIRTHPLACE (County & State, or foreign country) Ridgeland, S. Carolina	
14. MOTHER'S MAIDEN NAME Sarah Robinson		12. CITIZEN OF WHAT COUNTRY U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 155-05-8561	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		Address Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA, BILATERAL DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS +	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 31 19 61 to September 10 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 10 19 61 , and that death occurred on Sept. 10 19 61 at 3:25 P.M. from the causes and on the date stated above.		22a. SIGNATURE SEBASTIAN RUSSO, M.D.	
22b. DATE 9/11/61		22c. ADDRESS VAH, BALTIMORE 18 MD, FT. HOWARD DIVISION	
22d. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.		22e. ADDRESS VAH, BALTIMORE 18 MD, FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Ave., Balto. 17 Md.		25a. REC'D BY REGISTRAR SEP 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur E. Kline		25c. DATE SEP 15 '61	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11098

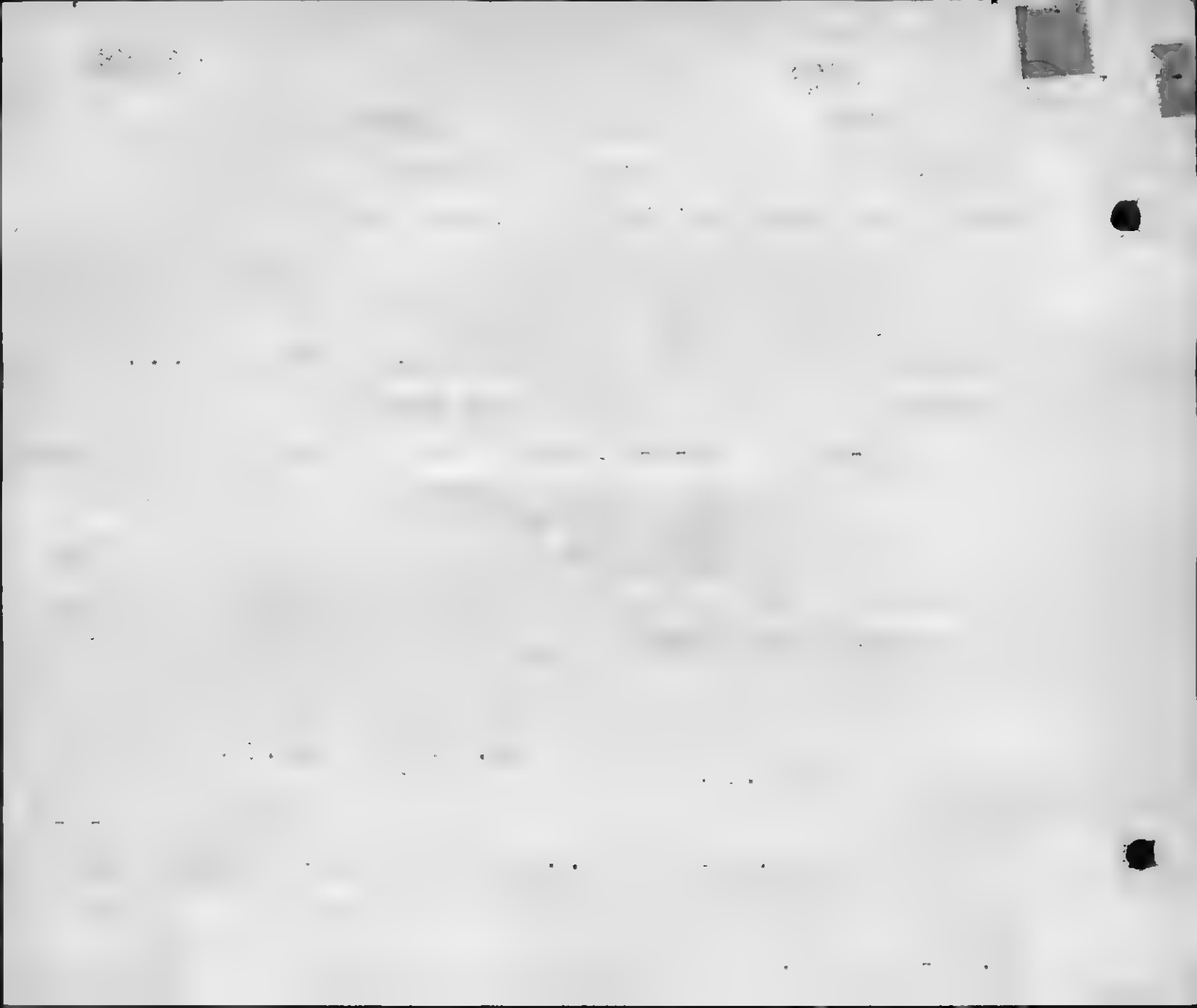
9928

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>X-1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>32 First Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE E HILL</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 14, 1893</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>September 30 1961</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Builder</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Dave Hill</u> 14. MOTHER'S MAIDEN NAME <u>Emma Rossmark</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>218-01-2473</u> 17. INFORMANT <u>Clin Rec VAH Baltimore Md Ft Howard Division</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO <u>CORONARY ARTERY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (b) <u>PULMONARY EDEMA</u> (c), stating the underlying cause last. DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>GENERALIZED ARTERIOSCLEROSIS</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>Sept. 28, 1961</u> Hour a.m. p.m. <u>9:30</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>VAH Baltimore Md</u> 20f. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 28, 1961</u> to <u>Sept. 30, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 30, 1961</u> , and that death occurred at <u>2 M</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Charles E. Rowan</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>9-30-61</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles E. Rowan</u> M.D. <u>VAH Baltimore Md - Ft Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-4-61</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Road Baltimore 14 Md</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Maryland</u> 25a. REC'D BY REGISTRAR <u>DACT 10 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kincaid</u>	

MEDICAL CERTIFICATION

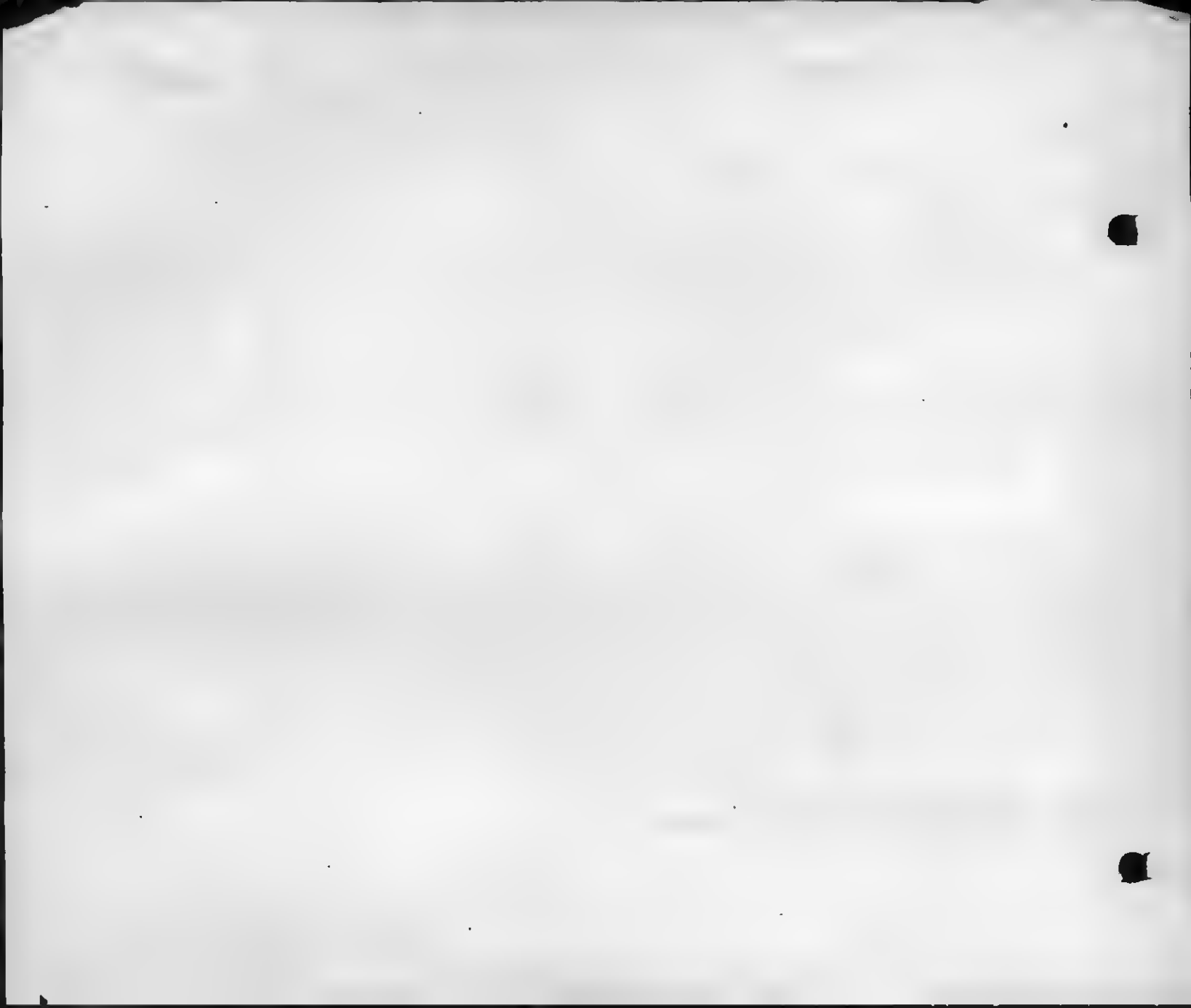
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1540 BORTON AVE</u>		d. STREET ADDRESS <u>1540 BORTON AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VENA</u> Middle <u>E</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1889</u>
9. AGE (In years last b rthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>HAMILTON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZ. ODOM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>2512 1VERSON ST. WASH. D.C.</u>	
17. INFORMANT <u>WM. HILL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary vascular accident</u> DUE TO <u>10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic cerebro-vascular disease</u> DUE TO <u>10 yrs</u> (c) <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>1 day</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1952</u> to <u>Sept 20, 1961</u> , that (I) <u>met last</u> saw the deceased alive on <u>Sept 20, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Louis Semenovoff</u>		22b. DATE SIGNED <u>9/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>		22d. ADDRESS <u>2108 CRENSHAW RD, BALTO 20, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-22-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>JEFFERSON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>JEFFERSON PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Connelly</u>		25a. RECEIVED BY REGISTRAR <u>25 '61</u>	
ADDRESS <u>4186 Eastern Blvd</u>		25b. REGISTRAR'S SIGNATURE <u>L. S. Thomas</u>	



14
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Director, State Health Department, may execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9930 Item 9 Film C294 9/11/61 99920

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Dundalk**
c. LENGTH OF STAY in lb **10 years**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **3456 Dunran Road**

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Dundalk (22)**
d. STREET ADDRESS **3456 Dunran Road**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **CLIFFORD CHARLES HISKER, Jr.**
4. DATE OF DEATH **September 1 19 61**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Nov. 7th, 1928** 9. AGE (In years, last birthday) **32 31** yrs. IF UNDER 1 YEAR: Months ☐ Days ☐ IF UNDER 24 HRS.: Hours ☐ Min. ☐

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Recorder** 10b. KIND OF BUSINESS OR INDUSTRY **Steel** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Clifford C. Hisker, Sr.** 14. MOTHER'S MAIDEN NAME **Elizabeth Epperson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **yes** 16. SOCIAL SECURITY NO. **46-47 218-22-3735** 17. INFORMANT **Mary B. Hisker** Address **same as #2**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Pulmonary Edema**
1-2-0-0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) **Arteriosclerotic Heart Disease.**
(c) DUE TO
cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

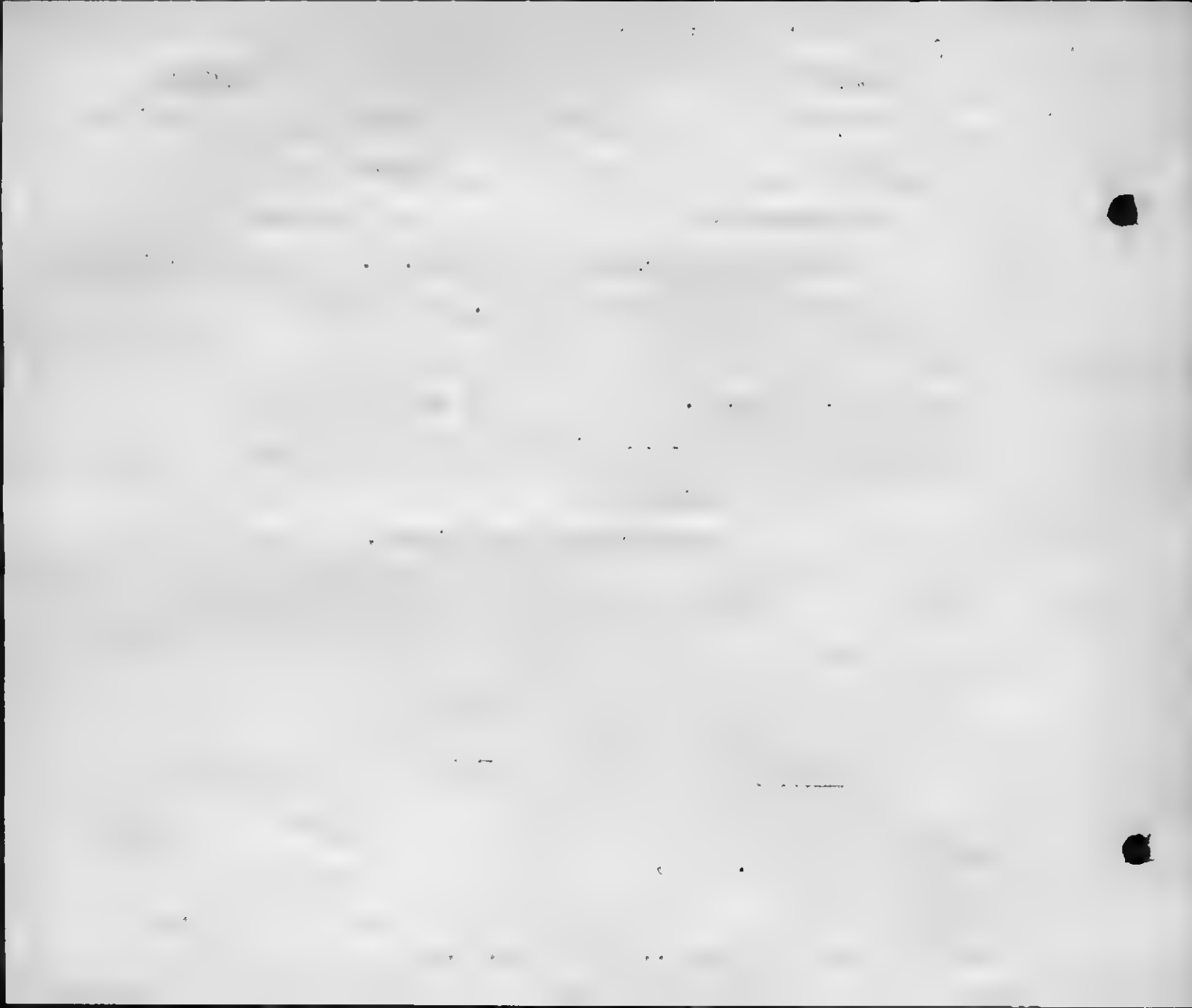
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Petty** M.D. DATE SIGNED **9/1/61**
EXAMINER'S NAME (Type) **Charles S. Petty** DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **9/5/61** 22c. NAME OF CEMETERY OR CREMATORY **Sacred Heart of Jesus** 22d. LOCATION (City, town, or country) (State) **Baltimore Co., Maryland**

23. FUNERAL DIRECTOR **Walter Brooks Bradley, Inc., Dundalk 22, Md.** ADDRESS **24 SEP 6 '61** 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE **Charles S. Petty**



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

9931

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTO. CO. - S. RUHL RD.

c. LENGTH OF STAY, IN 1b

50 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

S. RUHL RD.

3. NAME OF DECEASED
(Type or print)

KATIE

First

MAY

Middle

Last

HOFFHEISER

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

MAY 9, 1870

9. AGE (In years last birthday)

91

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

BALTO. CO., MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DAVID WIRTZ

14. MOTHER'S MAIDEN NAME

RUTH WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMATION Address School Hoffman, Maryland, Balto. Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

9. 1X

DUPLICATE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUPLICATE

(c)

GUNSHOT WOUND OF HEAD

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot by UNKNOWN ASSAILANT

20c. TIME OF INJURY

10

Month, Day, Year

9/3/61

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

S. RUHL RD - BALTO. CO MD

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

R.S. Fisher

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

9/4/61

EXAMINER'S NAME (Type)

R.S. Fisher

M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

SEPT. 7, 1961

22c. NAME OF CEMETERY OR CREMATORY

STILTZ CEMETERY RD #3 GLEN ROCK, PA.

22d. LOCATION (City, town, or country)

GLEN ROCK, PA.

(State)

23. FUNERAL DIRECTOR

J. Fred Hartman, New-Freedom, Pa.

24a. REC'D BY REG. STRAR

SEP 11 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

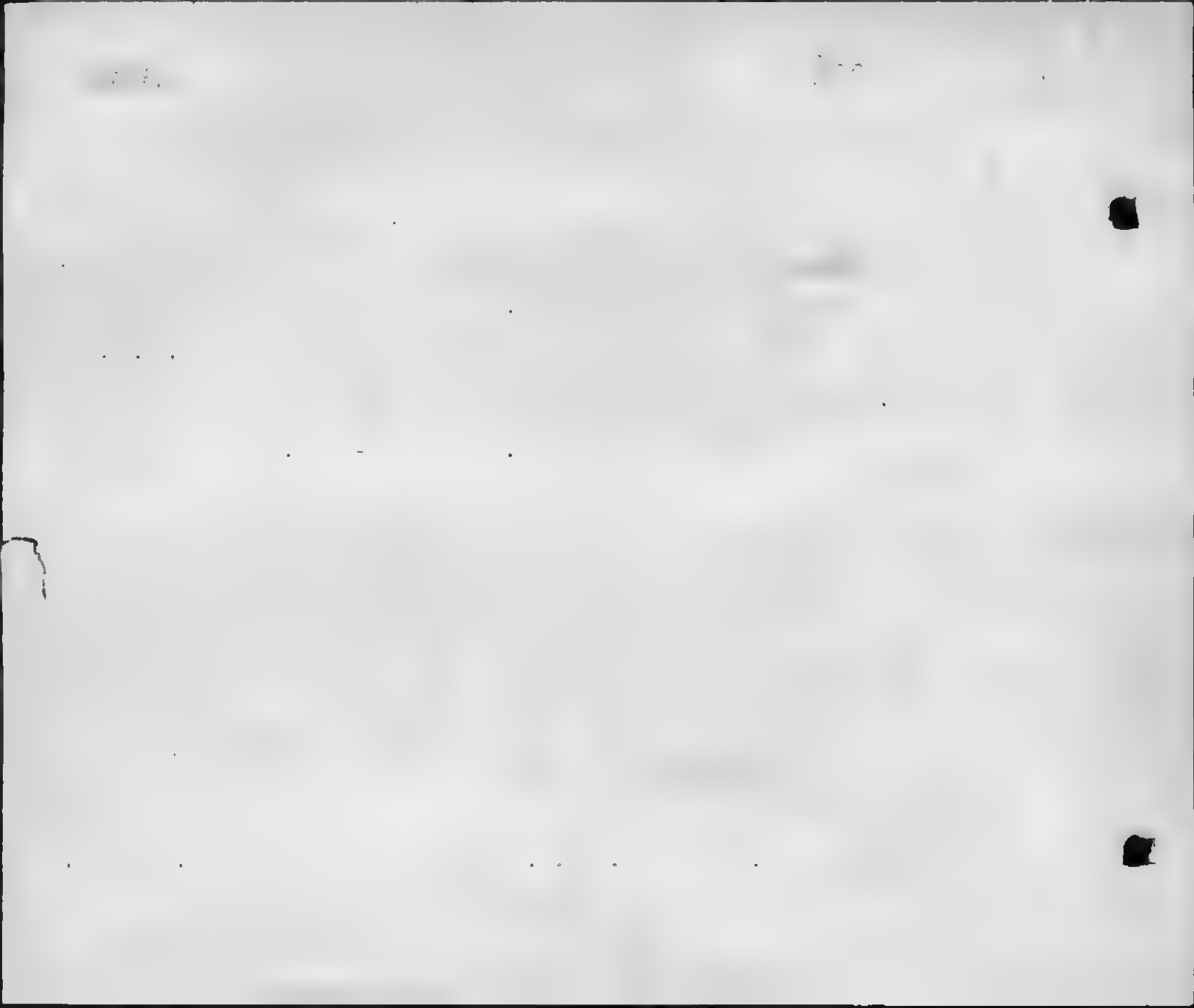
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9932

09922

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Anneslee	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 504 B Castle Drive		d. STREET ADDRESS 504 B. Castle Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah W Hoffman		4. DATE OF DEATH September 10 1961		5. AGE (In years last birthday) 85 yrs.	
5. SEX Female		6. COLOR White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 15, 1875		9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 10 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William A. Crawston		14. MOTHER'S MAIDEN NAME Annabelle Amos		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Mary Bozman-504 B. Castle Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 15. DUE TO Gravid abdominal metastasis Carcinoma of Gall Bladder		19. INTERVAL BETWEEN ONSET AND DEATH 1 yr. 9 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (I) (the hospital) attended the deceased from January 1, 1961 to Sept. 10, 1961 , that (I) (we) last saw the deceased alive on Sept. 9, 1961 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Charles E. Carr, Jr., M.D.		22b. DATE Sept. 13, 1961		22c. PHYSICIAN'S NAME (Type) Charles E. Carr, Jr., M.D.	
22d. ADDRESS 6201 York Road, Balto. 12, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS 6201 York Road, Balto. 12, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-13-61		23c. NAME OF CEMETERY OR CREMATORY Goyans Presbyterian	
23d. LOCATION (City, town or county) Baltimore, Maryland		23e. (State) Md.		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jackson & Sons, Inc.		24a. ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR SEP 13 '61	
24b. (City, town or county) Baltimore, Md.		24c. (State) Md.		24d. (Country) U.S.A.	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. ADDRESS Baltimore, Md.		25d. (City, town or county) Baltimore, Md.	
25e. (State) Md.		25f. (Country) U.S.A.		25g. (Country) U.S.A.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 11/59

9933

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence only) (Institution) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>9 Ritchie Highway</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>SAMUEL</u> Last <u>HOOK</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 24 1915</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT SEAMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WIPER-ENGINE ROOM</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ROBERT HOOK</u>		14. MOTHER'S MAIDEN NAME <u>MYRTLE HOLMES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-05-2972</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS FAR ADVANCED - ACTIVE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>OO 2 X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>APR. 6</u> 1961 to <u>SEPT. 16</u> 1961, that (I) (we) last saw the deceased alive on <u>SEPT. 16</u> 1961, and that death occurred <u>OVER</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Newcomer</u> M.D.		22b. DATE SIGNED <u>SEPT 16 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Newcomer, M.D. Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>		23d. LOCATION (City, town, or county) (State) <u>AA CO.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Schunow</u>		25a. REC'D BY REGISTRAR <u>SEP 19 61</u>	
ADDRESS <u>3615 Chestnut Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. K...</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

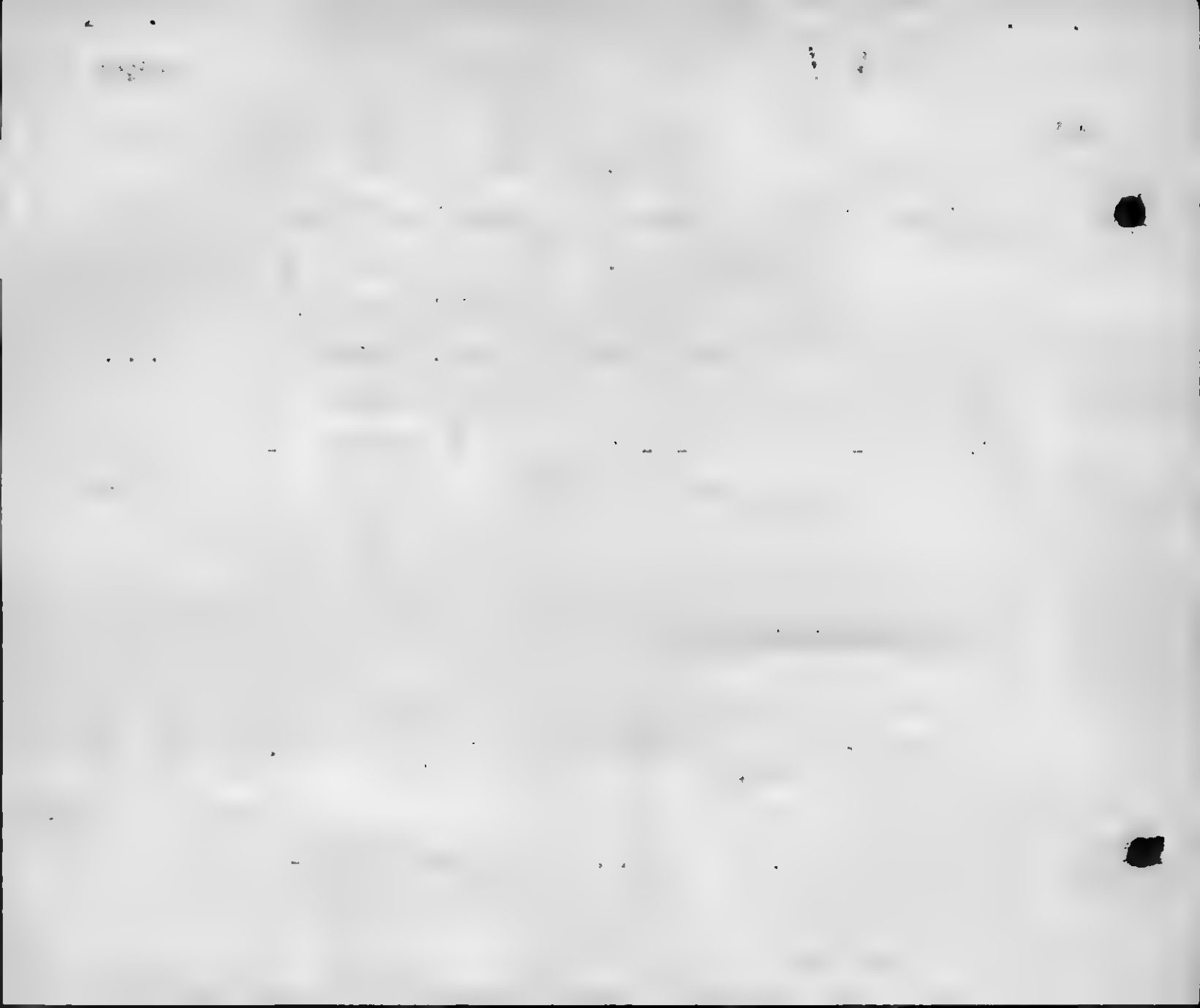
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09924

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 26 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3214 HAMILTON AVENUE d. STREET ADDRESS 3214 HAMILTON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERNARD A. HOUSE 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH FEBRUARY 14, 1898 9. AGE (In years last birthday) 63 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORIST 11. BIRTHPLACE (County & State, or foreign country) ELMIRA, NEW YORK 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES HOUSE 14. MOTHER'S MAIDEN NAME FRANCES BARRIAR 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 213-34-6272 17. INFORMANT CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF GINGIVA 144X DUE TO Conditions, if any, which gave rise to immediate cause (b) 144X (c), stating the underlying cause last. DUE TO PART OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVA. BETWEEN ONSET AND DEATH 2 YEARS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 15, 1961 to Sept. 10, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 10, 1961 , and that death occurred at 1:45 a.m. from the causes and on the date stated above.			
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) DANIEL R. ZOLL M.D. 22d. ADDRESS VAH BALTIMORE MD - FT HOWARD DIVISION		22b. DATE SIGNED 9-10-61 22e. MED. DIRECTOR <input type="checkbox"/> 22f. STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/13/61 24. FUNERAL DIRECTOR'S SIGNATURE John F Denry Funeral Home		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY 23d. LOCATION (City, town or county) BALTIMORE (State) MARYLAND 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 13 '61 Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

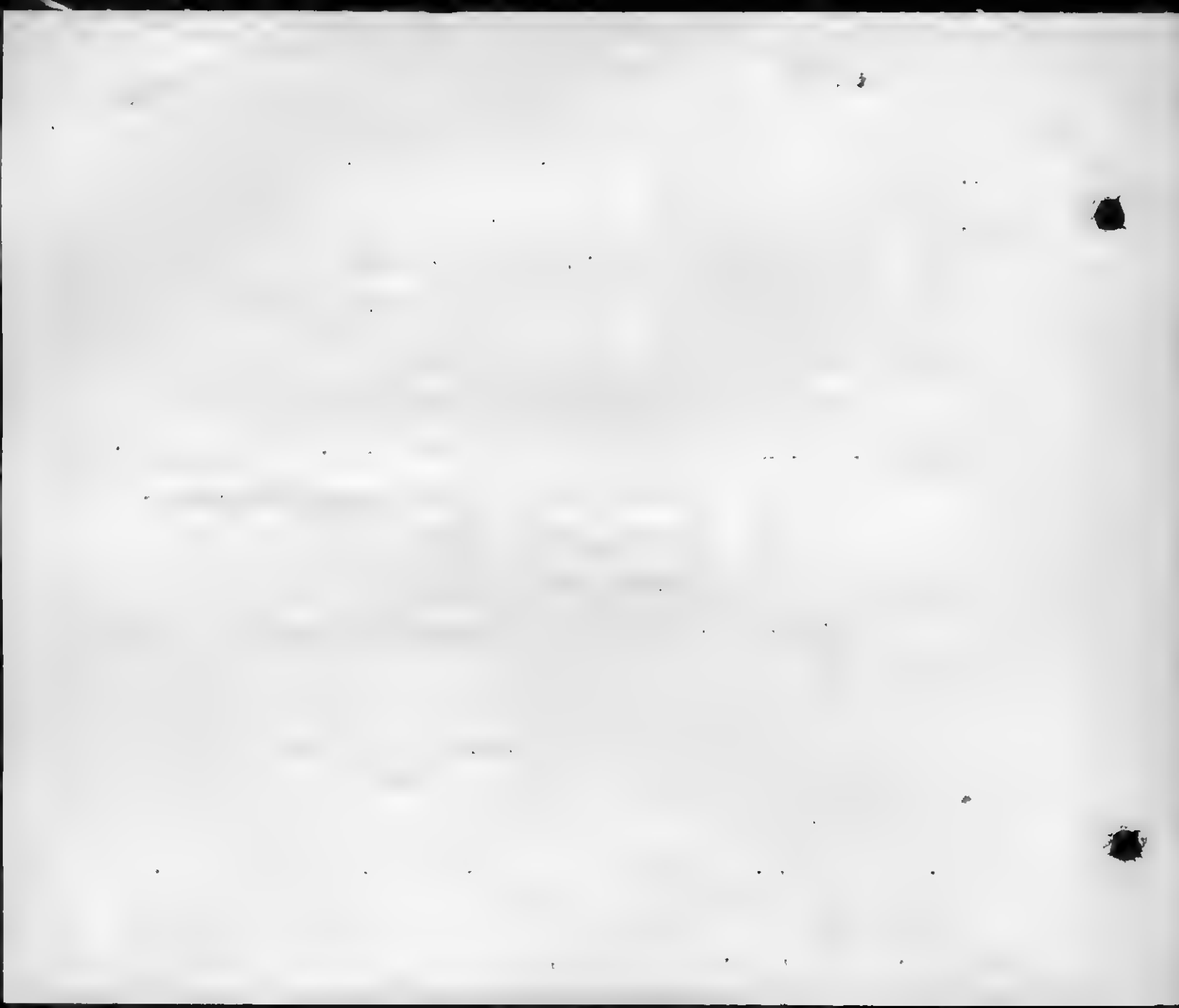
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9935

09925

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN IB <u>4 MO 18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>10603 S. DUNMOOR DR.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>HOVERMILL</u>				4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-1896</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James W. MATTHEWS</u>				14. MOTHER'S MAIDEN NAME <u>MARY McDEVITT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None?</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>FAR Adv. Pulmonary Tuberculosis</u> (b) <u>Empyema left.</u> (c) <u>Congestive Cardiac failure</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio Vascular disease.</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>4-28-1961</u> to <u>9-15-1961</u> , that (I) (we) last saw the deceased alive on <u>9-15-1961</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Newcomer</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>				22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner T. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

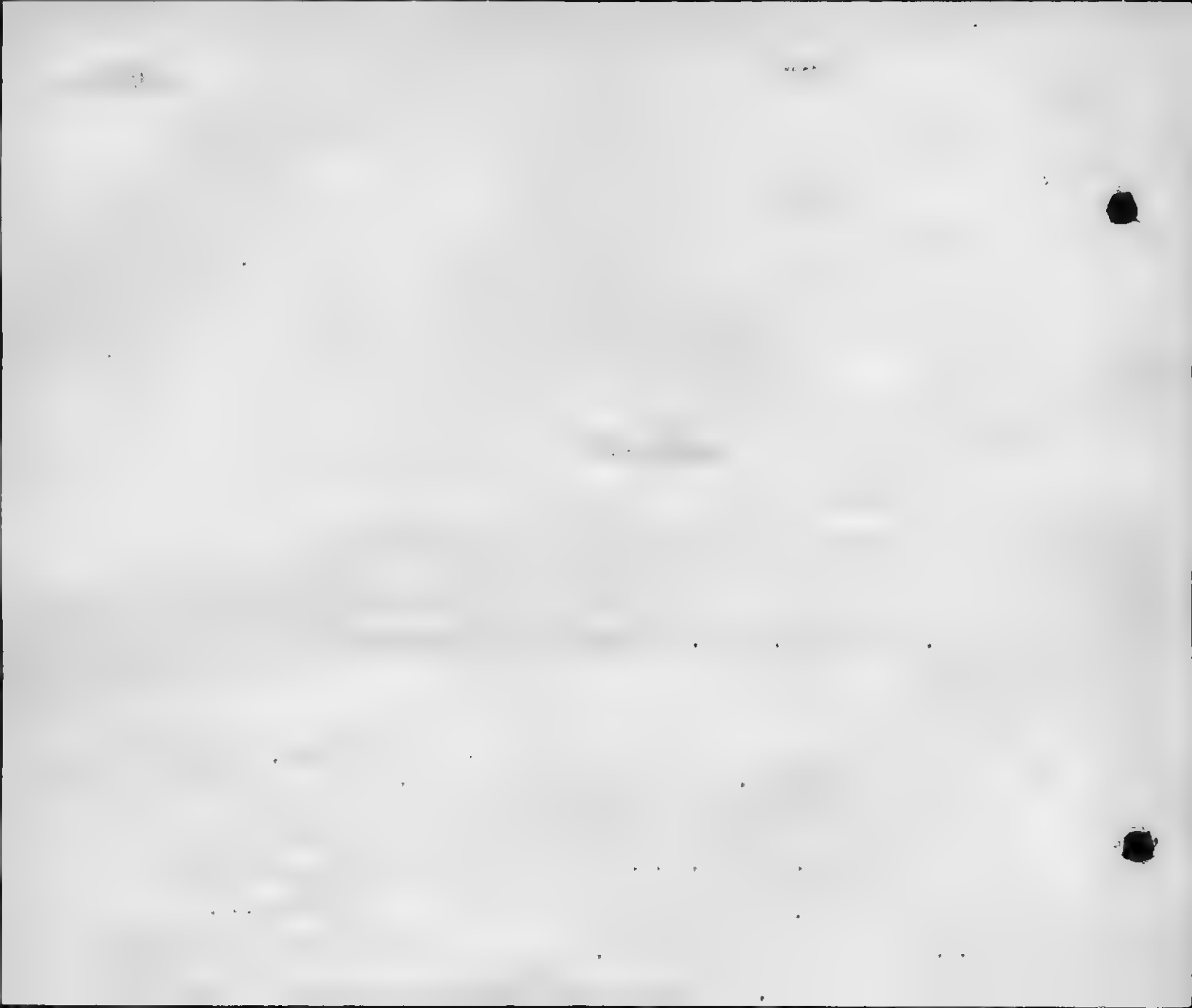
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9936

09926

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY in town <u>5yr11mth22dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>144 SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>5314 Wayne Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Maole Ireland</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF DEATH <u>Sept. 23, 1961</u> 9. AGE (in years last birthday) <u>79</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1961</u> 13. FATHER'S NAME <u>Thomas Ireland</u> 14. MOTHER'S MAIDEN NAME <u>Fannie Howard Baseman</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>134-10-9169</u> 17. ADDRESS OF INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> 18. CAUSE OF DEATH [Enter only one cause per line; (e), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Chron. Brain Syndr. assoc. with cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Chron. Brain Syndr. assoc. with cerebral arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year: <u>Sept. 30, 1955</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>SPRING GROVE STATE HOSPITAL</u> 20f. (City or town) <u>Catonsville</u> (County) <u>Maryland</u> (State) <u>Md.</u>		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 30, 1955</u> , to <u>Sept. 23, 1961</u> , that (1) (we) last saw the deceased alive on <u>Sept. 23, 1961</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Jose R. Arizaga, M.D.</u> 22b. DATE SIGNED <u>9/23/61</u> 22c. PHYSICIAN'S NAME (Type) <u>Jose R. Arizaga, M.D.</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Sept. 25, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Finksburg</u> 23d. LOCATION (City, town or county) <u>Finksburg, Md.</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u> ADDRESS <u>Reisterstown, Md.</u> 25a. REC'D BY REGISTRAR <u>SEP 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

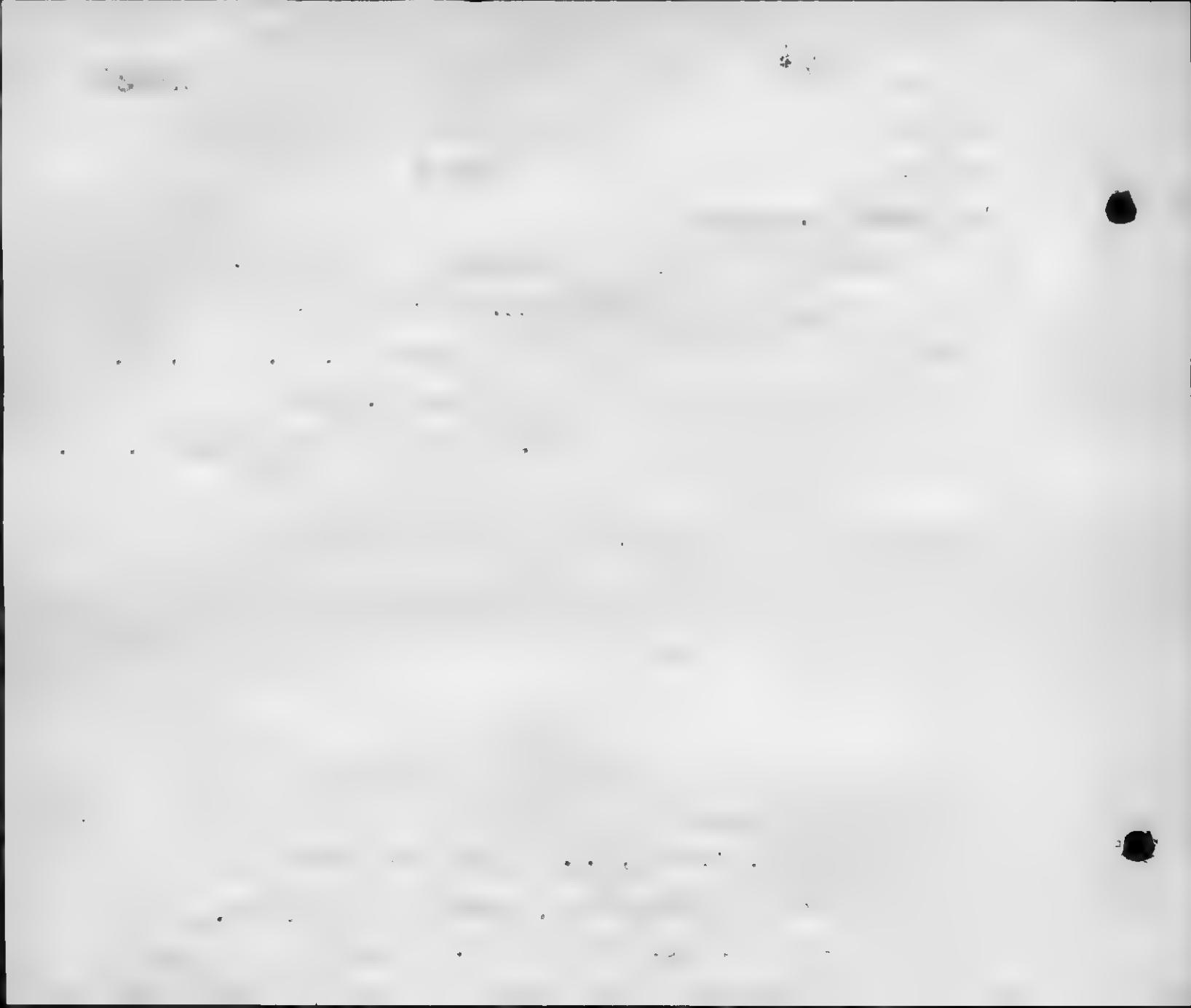


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/80

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9937 CERTIFICATE OF DEATH 09927											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Timonium c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 114 Oakway Rd. Timonium						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenarm d. STREET ADDRESS ---					
3. NAME OF DECEASED (Type or print) VELMA L ISENNOCK						4. DATE OF DEATH Sept. 30 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 11, 1907		9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk						10b. KIND OF BUSINESS OR INDUSTRY Harford Co. Md.					
13. FATHER'S NAME Walter L Crowl						14. MOTHER'S MAIDEN NAME Hannah L. Iley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. ---					
17. INFORMANT Mrs. Velma I Eyre						Address 114 Oakway Rd. Tim.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 170X METASTATIC CARCINOMA DUE TO CARCINOMA OF LEFT BREAST Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO ---											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---			
20f. (City or town) ---				20g. (County) ---				20h. (State) ---			
21. I certify that (I) (this hospital) attended the deceased from 7/29 19 61 , to 9/30 19 61 , that (I) (we) last saw the deceased alive on 9/29 19 61 , and that death occurred at 8 A.M. , from the causes and on the date stated above.											
22a. SIGNATURE William A. Pillsbury 22b. DATE SIGNED 9/30/61											
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury, M.D. 22d. ADDRESS Timonium, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/3/61				23c. NAME OF CEMETERY OR CREMATORY Belair Mem. Gardens			
23d. LOCATION (City, town or county) Belair, Md.				23e. REC'D BY REGISTRAR OCT 2 '61				23f. REGISTRAR'S SIGNATURE Arthur L. K...			
24. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson, Inc. 1050 York Rd.											



9938

CERTIFICATE OF DEATH

Reg. Dist. No. 09928

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Oella</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>933 Oella Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD LEON JACKSON</u>				4. DATE OF DEATH Month Day Year <u>Sept. 7, 1961</u> <u>19</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woolen Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Lewiston Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clarence L. Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Florence H. Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		INFORMANT Address <u>Clarence Jackson, 933 Oella Ave. Oella Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cachexia of Sebaceous Glands</u> <u>179.7</u> "DUE TO" Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Seminal Vesicles 1 year</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1961</u> to <u>9/7/61</u> , that I last saw the deceased alive on <u>8/25/61</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Paris Phillips M.D. University Hospital 9/8/61</u>							
ACTUAL SIGNATURE <u>Paris Phillips</u>				PHYSICIAN'S NAME (Type) <u>PARIS PHILLIPS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F.C. Higginbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-11-8

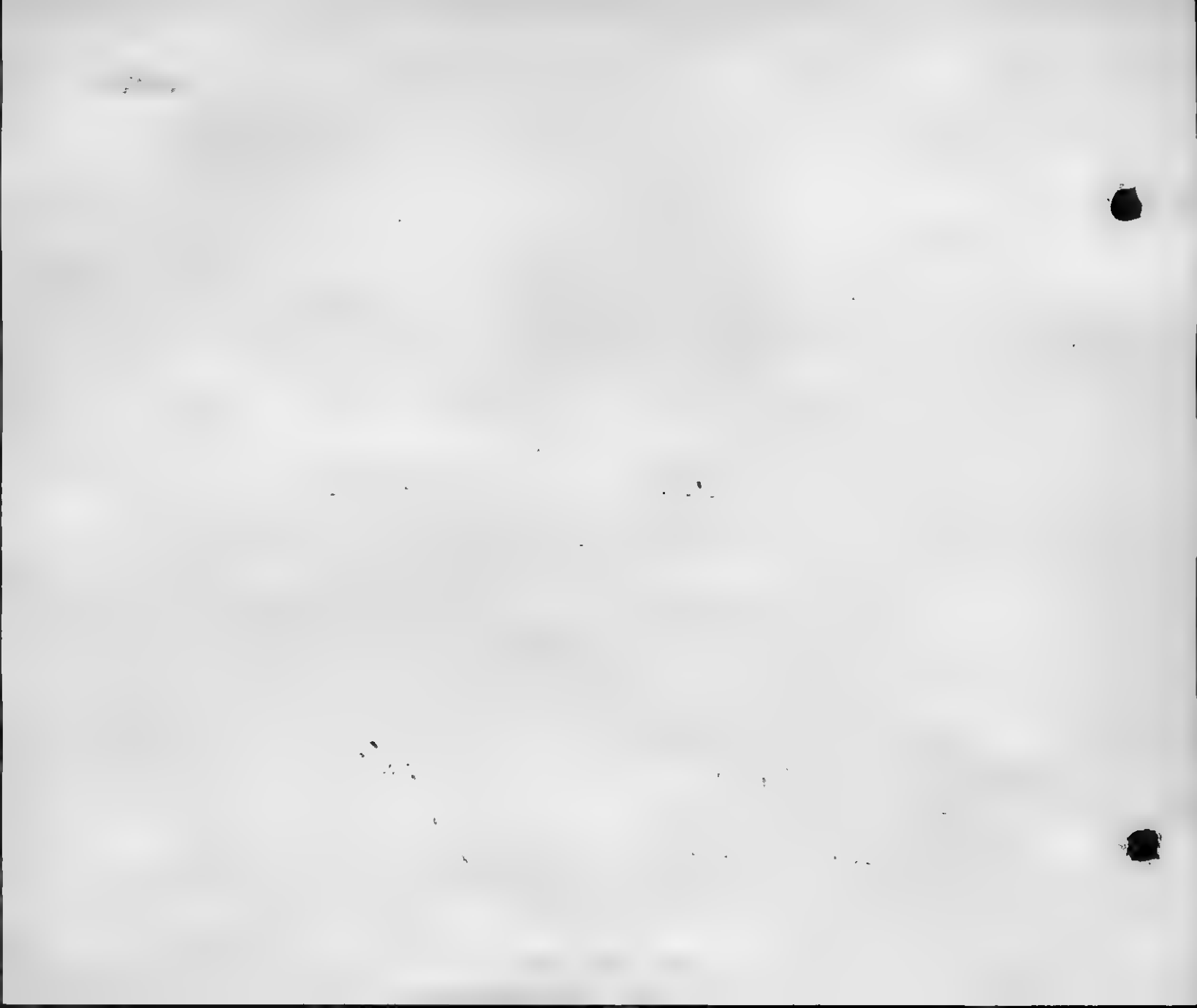
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician, and in by the funeral director. After this certificate has been signed by the attending physician and complete carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
15M 9/60

9939

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MONKTON</u> c. LENGTH OF STAY IN 1b <u>72 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MONKTON</u> d. STREET ADDRESS <u>TROYER ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>JOANNA JACKSON</u> First Middle Last		4. DATE OF DEATH <u>SEPT. 1 1961</u> Month Day Year	
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WOLORED</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>APRIL 22 1889</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(RETIRED) HOUSE WORK</u> 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CO. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JESSIE LEWIS</u> 14. MOTHER'S MAIDEN NAME <u>FANNIE BERRY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <u>NO</u> (If yes give war and dates of serv. co.) 16. SOCIAL SECURITY NO. <u>315-32-1246</u> 17. INFORMANT <u>WILLIAM E. LEWIS</u> Address <u>TROYER ROAD MONKTON MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> DUE TO (b) <u>Arterio sclerotic Cardiovascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1959</u> to <u>August 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 1 1961</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Herbert Mueller Jr</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>PARKTON MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE, THEREOF <u>9/4/1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MT. JOY</u> 23d. LOCATION (City town or county) (State) <u>MONKTON MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u> ADDRESS <u>Jarrettsville Md.</u> 25a. REC'D BY REGISTRAR <u>SEP 5 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9940

CERTIFICATE OF DEATH

99930

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30	
c. LENGTH OF STAY IN 1b 169 Days		d. STREET ADDRESS 768 McHenry Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PHILIP S. KELLY		4. DATE OF DEATH Month Day Year September 13 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 1, 1889
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
11. BIRTHPLACE (County & State, or foreign country) Neosho, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Luke A. Kelly		14. MOTHER'S MAIDEN NAME Anna Rooney	

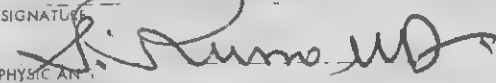
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 212-16-0813	
17. INFORMANT Clinical Records, VA Hospital, Baltimore 18, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY FIBROSIS AND EMPHYSEMA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

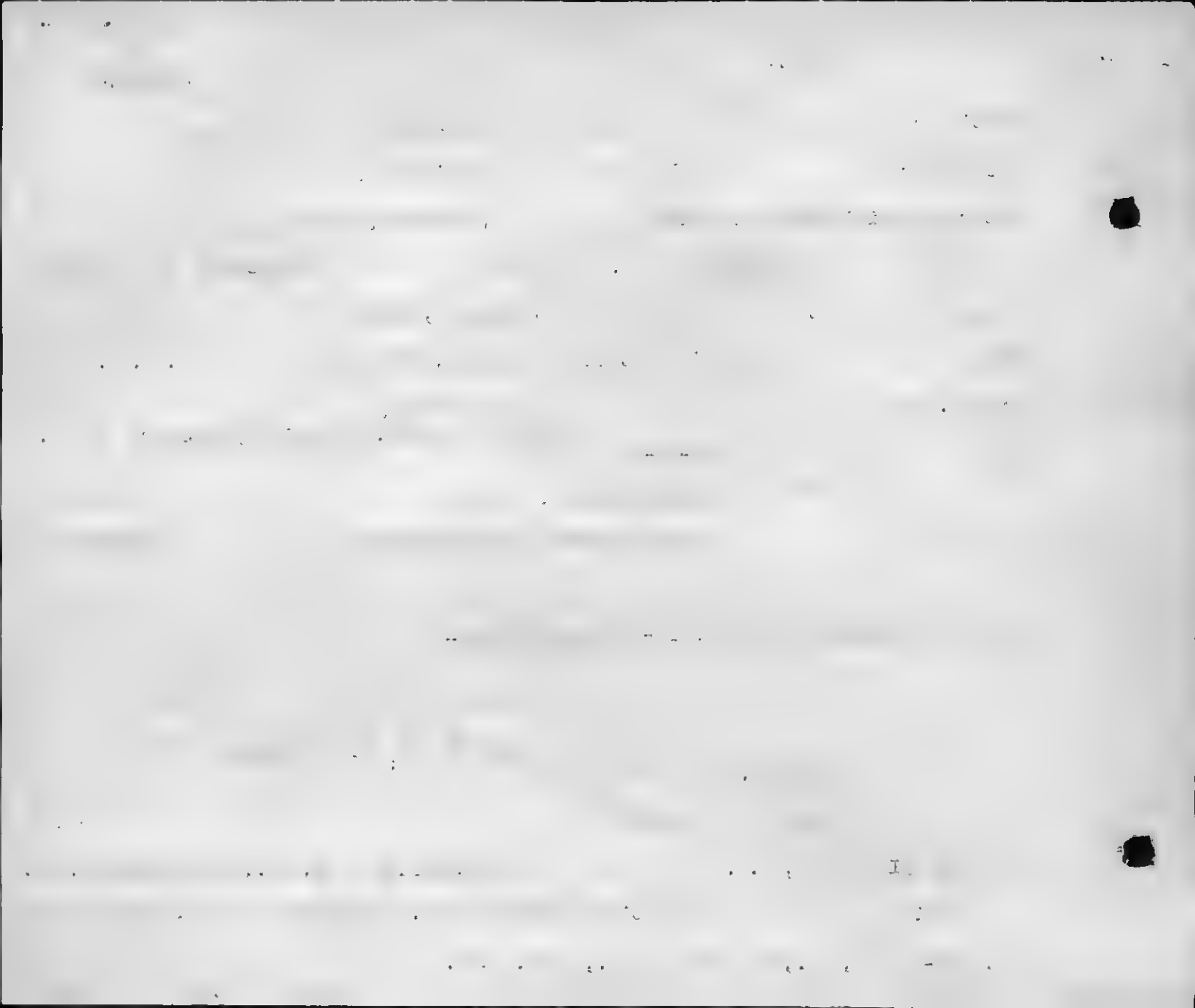
21. I certify that ☒ (this hospital) attended the deceased from **March 28 1961** to **September 13/61** that ☒ (we) last saw the deceased alive on **Sept. 13 1961**, and that death occurred at **10:20 PM**, from the causes and on the date stated above.

22a. SIGNATURE 	22b. DATE SIGNED 9/14/61
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.	22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD MD. DIV.

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE THEREOF 9-19-61	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland
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24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.	25a. REC'D BY REGISTRAR SEP 18 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be relayed by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09931

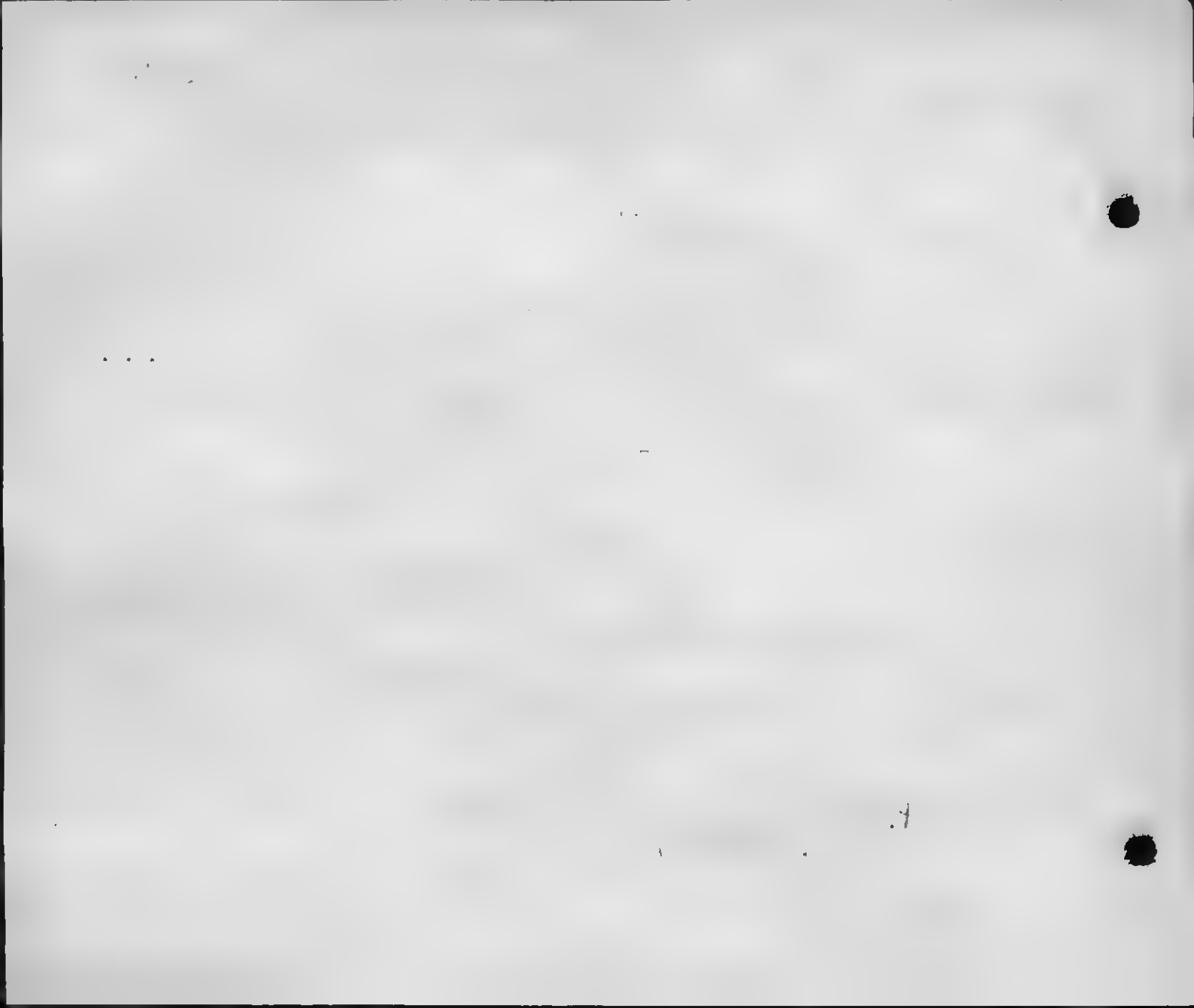
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House In The Pines Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u> d. STREET ADDRESS <u></u>	
3. NAME OF DECEASED (Type or print) <u>NATHANIEL SMITH KENNEY</u>		4. DATE OF DEATH <u>8th September 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>22 Sept. 1874</u>		9. AGE (in years, if over 1 year, last birthday) <u>86</u> yrs. 10. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown) Cluak</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Richard C. Kenney</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>1530</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>5-14-1961</u> to <u>9-8-1961</u>, that (I) (we) last saw the deceased alive on <u>9-8-1961</u>, and that death occurred at <u>2P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u>9/8/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		22d. ADDRESS <u>6609 Frederick Ave., Balt. 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11 Sept. 61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Brington</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



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TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9942
99932
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights d. STREET ADDRESS 423 49th Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert W King		4. DATE OF DEATH Sep tember 16 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Henry King		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-10-6137	
17. INFORMATION Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia and azotemia DUE TO (b) Pyelonephritis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), STATING THE UNDERLYING CAUSE LAST. DUE TO (c) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks ?	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-21-61 , 19 59 , to 9-16-61 , 19 61 , that (I) (we) last saw the deceased alive on 9-16-61 , 19 61 , and that death occurred at 12 noon , from the causes and on the date stated above.			
22a. SIGNATURE H.I. Cholmondeley		22b. DATE SIGNED 9-16-61	
22c. PHYSICIAN'S NAME (Type) H.I. Cholmondeley		22d. ADDRESS Spring Grove State Hospital, Balt 28	
23a. BURIAL, CREMATION, or other disposition of body BURIAL		23b. DATE THEREOF 9/24/61	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City, town or county) (State) COLMAR MARSH R 650, MD	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co - 517-1195456		25. REC'D BY REGISTRAR SEP 19 '61	
ADDRESS WASH DC		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



9943

CERTIFICATE OF DEATH

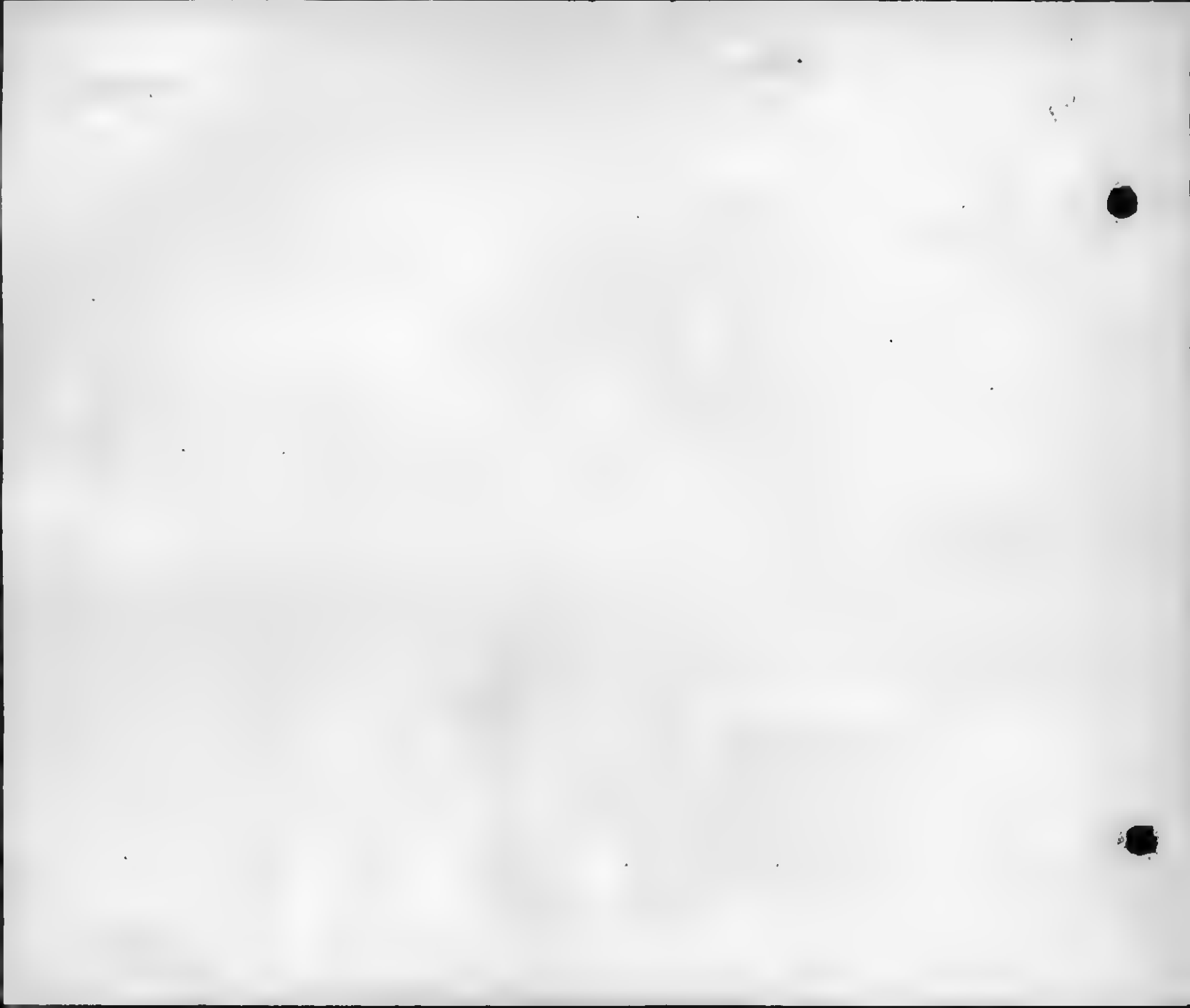
Reg. Dist. No. 09933

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Pyrlmth 14 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle Kitson Last Kitson		4. DATE OF DEATH Month 9 Day 9 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1876
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Rohleder		14. MOTHER'S MAIDEN NAME Susan Lutz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral circulatory failure 21 X DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 15 mins
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from Sept. 12, 1956 to 9/9/61 , that I last saw the deceased alive on 9/9/61 , 19 — , and that death occurred at 4:47 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED —			
ACTUAL SIGNATURE Jose R. Arizaga, M.D.		PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-12-61	
22c. NAME OF CEMETERY OR CREMATORY Orem's Cemetery		22d. LOCATION (City, town, or county) (State) Middle River, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson 4		24a. REC'D BY REGISTRAR SEP 13 '61	
24b. REGISTRAR'S SIGNATURE —		24c. REGISTRAR'S SIGNATURE —	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



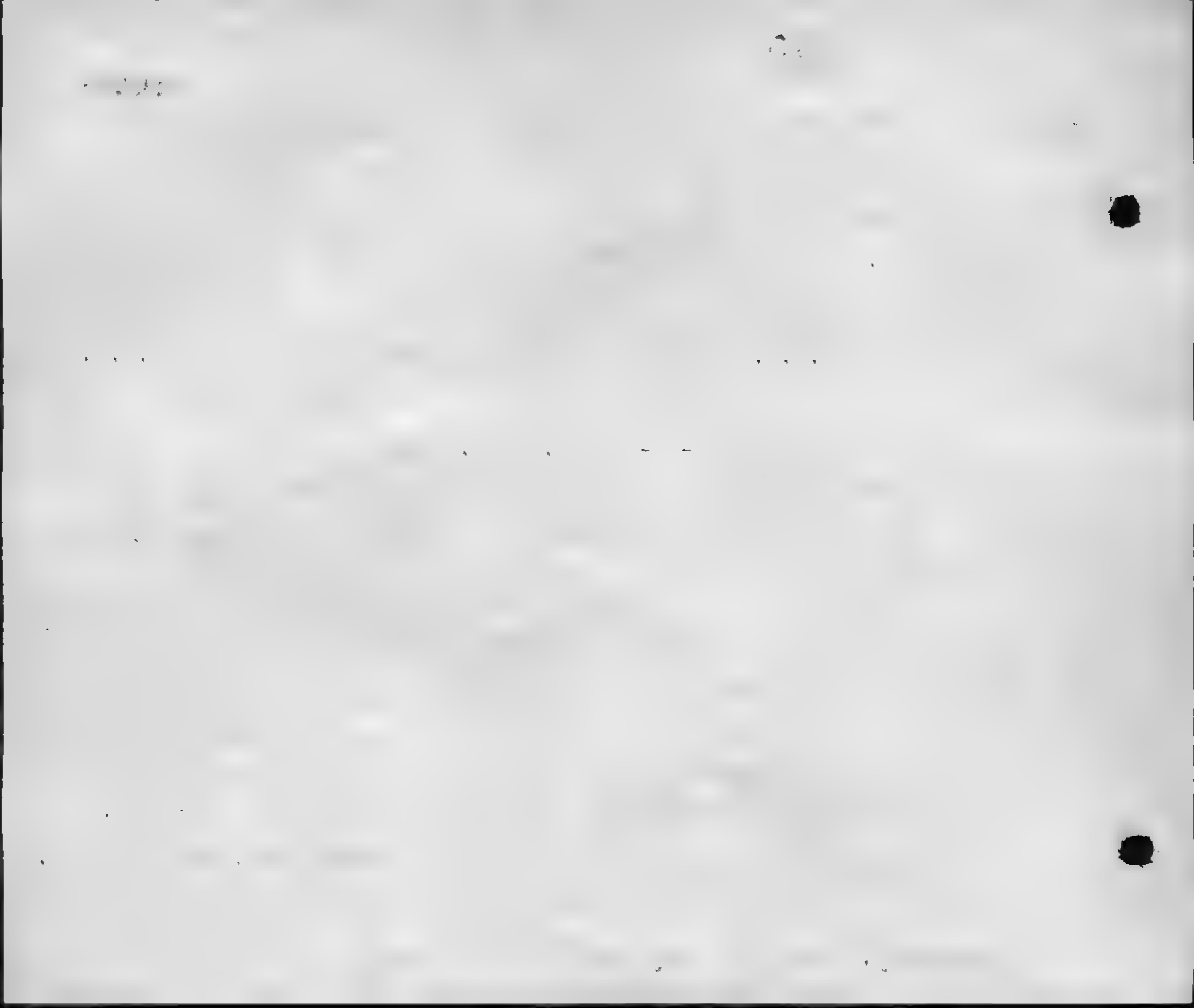


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9945 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2905 Summit Avenue</u>				e. STREET ADDRESS <u>2905 Summit Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Robert Elmer Knickman</u>				4. DATE OF DEATH <u>September 20 19 61</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 5, 1891</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>watchman, N.B.C.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Ann Herromanus</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO <u>218-18-1438 A</u>				17. INFORMANT <u>Mrs. Florence Knickman</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. * PATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abd. Generalized Carcinoma</u> <u>1538</u> DUE TO <u>Lower Bowel Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>6 mos.</u> DUE TO (c) <u>6 mos.</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cachexia + edema</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 61</u> to <u>Sept 20 61</u> , that (I) (we) last saw the deceased alive on <u>Sept 19 61</u> , and that death occurred at <u>9 AM</u> from the causes and on the date stated above											
22a. SIGNATURE <u>Frank T. Kasik</u> M.D.				ATTENDING PHYS. <u>9/21/61</u>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>9/21/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank T. Kasik</u>				22d. ADDRESS <u>9005 Harford Road, Balto 14, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/23/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Belaire Memorial Pk</u>			
23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>				25a. REC'D BY REGISTRAR <u>SEP 22 '61</u>			
								25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

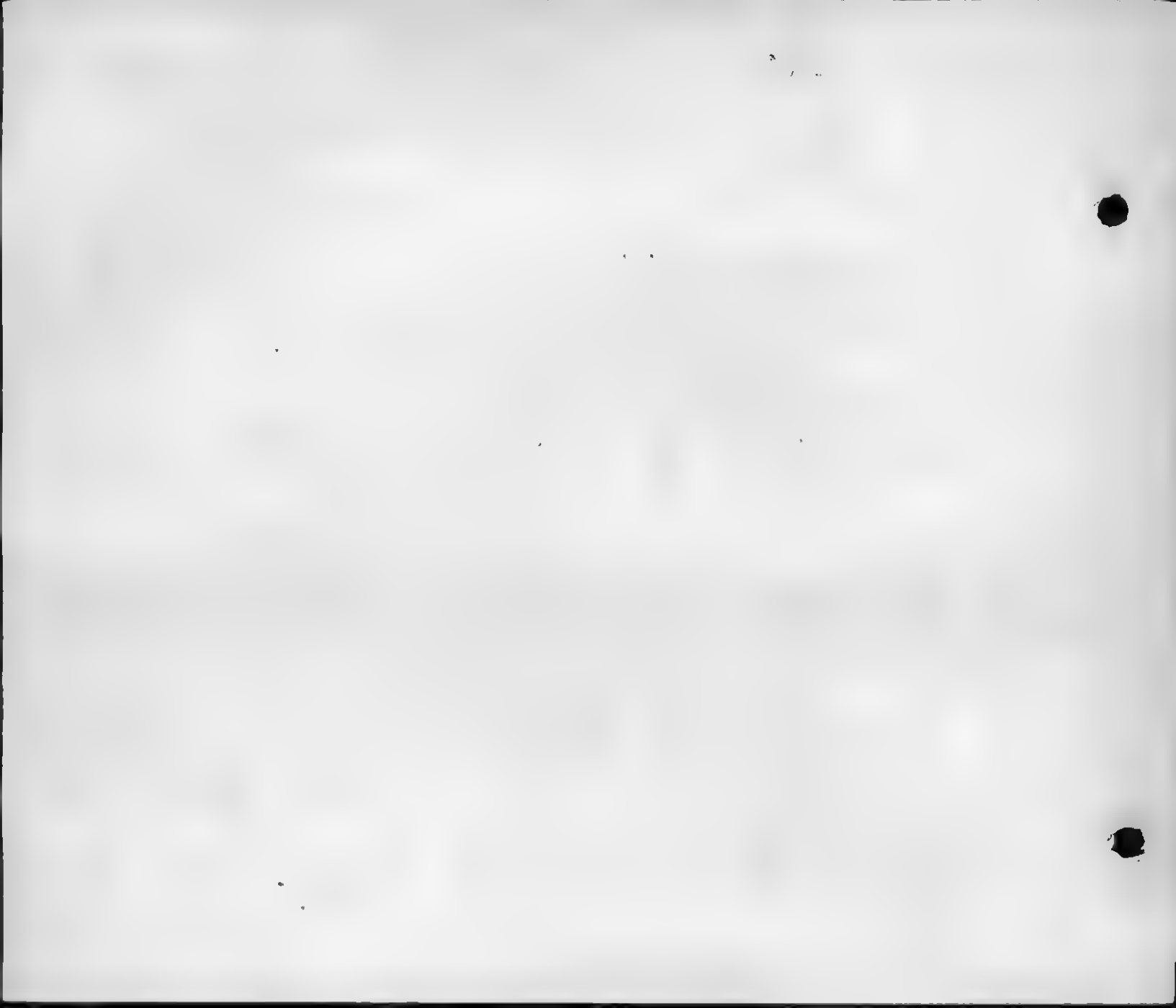
9946

CERTIFICATE OF DEATH

Reg. Dist. No.

09936

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2106 Lukewood Drive				d. STREET ADDRESS 2106 Lukewood Drive			
3. NAME OF DECEASED (Type or print) First PAULA Middle S.C. Last KRON				4. DATE OF DEATH Month 9 Day 21 Year 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1903	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 18 Days 00 Hours 00 Min.	IF UNDER 24 HRS. Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (State or foreign country) Bloomington, Ill.	
12. CITIZEN OF WHAT COUNTRY? none			13. FATHER'S NAME Paul Brandhuber				
14. MOTHER'S MAIDEN NAME Mary Zimmerman			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				
16. SOCIAL SECURITY NO. -			17. INFORMANT Mr. Chris Kron				
18. ADDRESS 2106 Lukewood Drive			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 151X DUE TO (c) 151X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 151X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Nov 1959 to Sept. 21, 1961 , that I last saw the deceased alive on Sept. 21, 1961 , and that death occurred at 3:10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Nelson McKay				DATE SIGNED 6014 Edmondbrook Dr. Sept 23, '61			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/25/61	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem	22d. LOCATION (City, town, or county)	(State) Balto.			
23. FUNERAL DIRECTOR'S SIGNATURE WIEDEFFELD & SON GREENMOUNT AVE & 22ND				24a. REC'D BY REGISTRAR SEP 26 '61			
24b. REGISTRAR'S SIGNATURE Carlton S. Turner							



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9947
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Resident before admission) a. Maryland b. COUNTY B			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stonleigh			c. LENGTH OF STAY IN 1b 2 Wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Armacest Nursing Home				d. STREET ADDRESS 312 E. Melrose Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) BEATRICE LEANORE KRUSEN First Middle Last				4 DATE OF DEATH Sept. 19 , 19 61 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1900		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter L. Lewis				14. MOTHER'S MAIDEN NAME Lillian Strobel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John C. Krusen 312 Melrose, Balto. 12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MELANO-SARCOMA (RIGHT EYE) DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS 3 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADENO-CARCINOMA-SIGMOID COLON							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from FEB. 9, 1960 to SEPT. 19, 1961 , that (I) lost saw the deceased alive on SEPT. 19, 1961 , and that death occurred at 2:45 PM , from the causes and on the date stated above							
22a. SIGNATURE Arthur Karfagin				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ARTHUR KARFAGIN M.D.				22d. ADDRESS 1532 HAVENWOOD ROAD BALTIMORE 18			
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 9-22-61		23c. NAME OF CEMETERY OR CREMATORY Lorraine		23d. LOCATION (City town or county) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank. Newell				ADDRESS Pikesville, md		25a. REC'D BY REGISTRAR DATE SEP 21 '61	
				25b. REGISTRAR'S SIGNATURE Carlton S. K...			

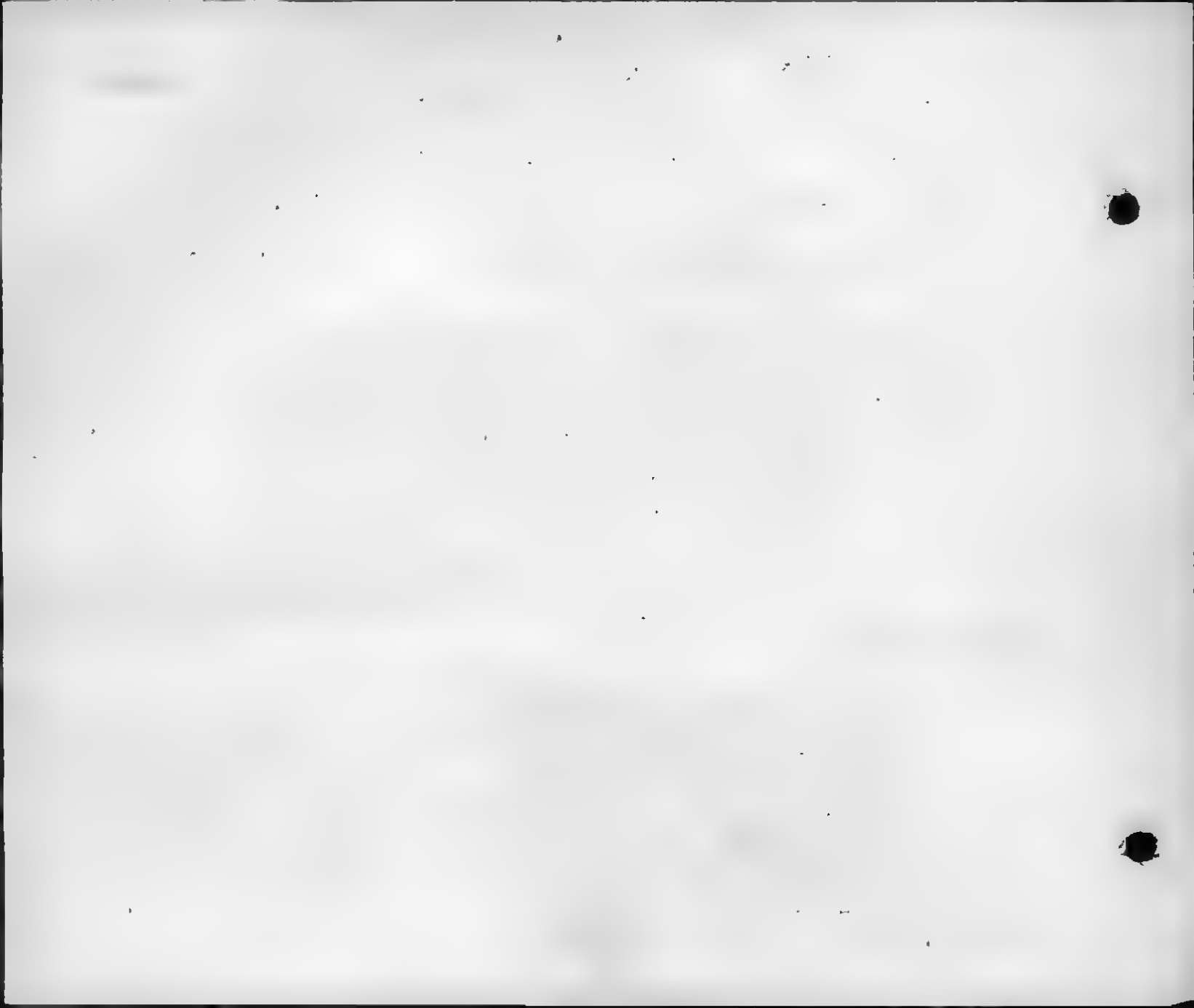
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9948

CERTIFICATE OF DEATH

09938

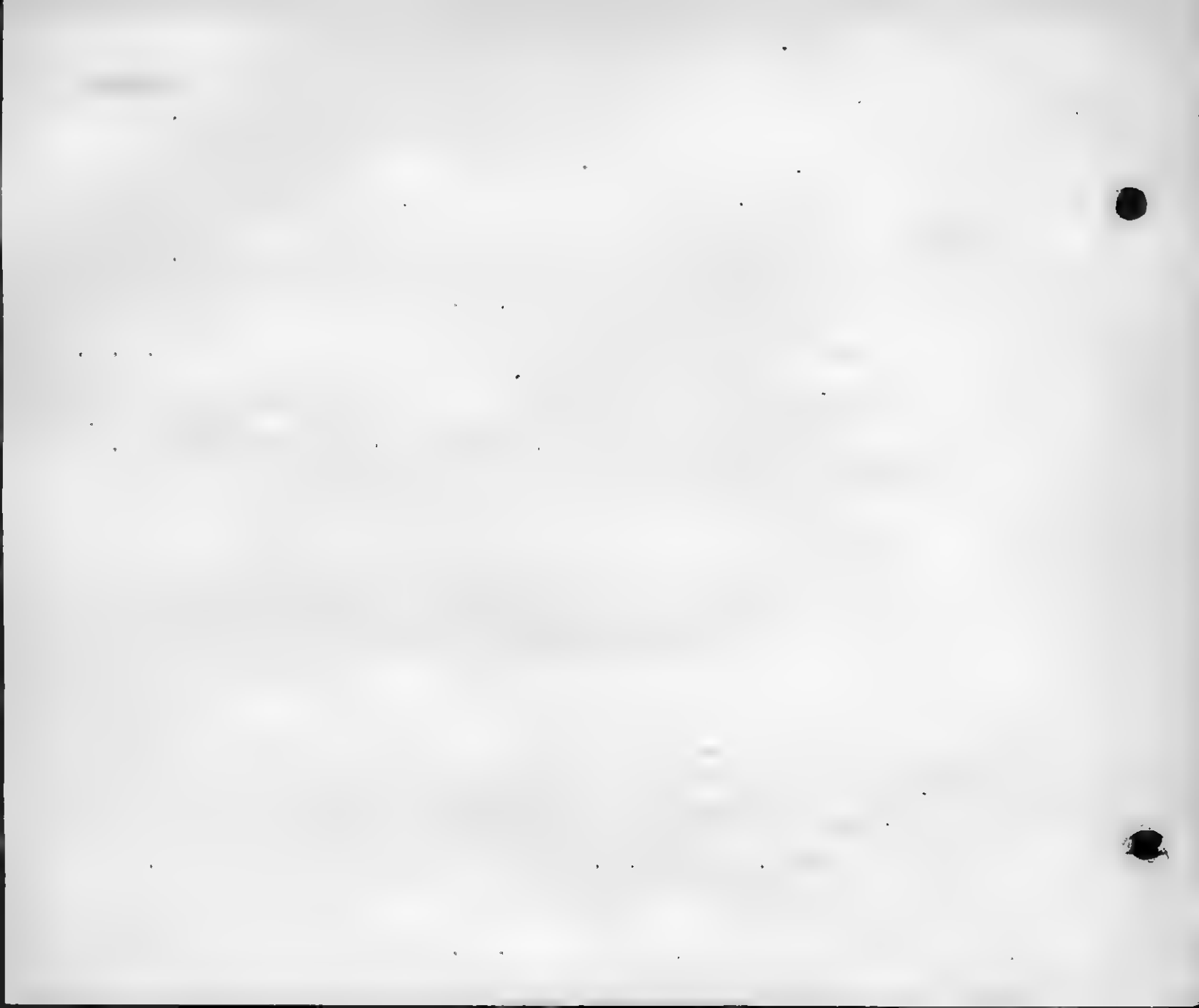
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence and no institution) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 76 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Westchester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Lilley Last Lafferty		4. DATE OF DEATH Month Sept. Day 21 Year 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery store		10b. KIND OF BUSINESS OR INDUSTRY Retail	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Lafferty		14. MOTHER'S MAIDEN NAME Martha Lilley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-02-3768	
17. INFORMANT Address Catonsville, Md.		18. MRS. MARGARET McGUIRK 24 Westchester Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma, Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 18 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan. 18, 1958 to Sept. 21, 1961 that (1) (we) last saw the deceased alive on Sept. 19, 1961 , and that death occurred at 11:30 PM , from the causes and on the date stated above			
22a. SIGNATURE Thomas F. Herbert M D		22b. DATE SIGNED 9-22-61	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert M. D.		22d. ADDRESS Church Road Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/25/1961	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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MEDICAL CERTIFICATION



TO HOSTS: THE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09939

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River c. LENGTH OF STAY IN 1b 6 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holybeach avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY 27 HOWARD COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE * HARVARD PARK d. STREET ADDRESS 6904 ATHOL AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF CHARLES LAYMAN-KAZYS LAMANTAVICUS (Type or print) also known as		4. DATE OF DEATH SEPT. 5 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Keeper		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Lithuanian		12. CITIZEN OF WHAT COUNTRY Lithuania	
13. FATHER'S NAME Vincas Lamantavicus		14. MOTHER'S MAIDEN NAME Ursula Merkevicuite	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-05-9139-A	
17. INFORMANT Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 156.1 DUE TO UNDETERMINED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIO-VASCULAR-RENAL DISEASE DUE TO ARTERIOSCLEROSIS (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YEARS 5 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 2 JUNE 19 61 to 5 SEPT 19 61 , that (I) (we) last saw the deceased alive on 3 SEPT 19 61 , and that death occurred at 4:10 PM from the causes and on the date stated above.			
22a. SIGNATURE Edward F. Milan		22b. DAY SIGNED 6 SEPT 19 61	
22c. PHYSICIAN'S NAME (Type) EDWARD F. MILAN, M.D.		22d. ADDRESS 682 WASHINGTON BLVD Z30 BALTIMORE 30 MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 9/61	
23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION (City, town or county) (State) Belair Rd. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles W. Sackman		24b. ADDRESS 637 West Blvd	
25a. REC'D BY REGISTRAR SEP 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	

[illegible]

Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains.

Nothing Was Granted Freely

9950

CERTIFICATE OF DEATH

Reg. Dist. No.

09940

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joyce Middle LAWSON Last N		4. DATE OF DEATH Month 9 Day 25 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/84
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months 7 Days 10	IF UNDER 24 HRS. Hours 11 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Physician		10b. KIND OF BUSINESS OR INDUSTRY Bathhouse	11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Benjamin Lawson	
14. MOTHER'S MAIDEN NAME Margaret Stockman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Personal History & Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 36 hrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/21 19 58 , to Sept 25 19 61 , that I last saw the deceased alive on Sept 25 19 61 , and that death occurred at 12:14 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milton B. Kress M.D.		ADDRESS (Street, city or town, state) Eudowood Sanatorium, Md.	
PHYSICIAN'S NAME (Type) Milton B. Kress, M. D. Eudowood Sanatorium, Towson 4, Maryland		DATE SIGNED 9/25/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-28-61	
22c. NAME OF CEMETERY OR CREMATORY MORELANDS		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connelly		ADDRESS 418 Eastern Blvd.	
24a. REC'D BY REGISTRAR SEP 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kress	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11138

Reg. Pk. No. 03412

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Dauphin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Parkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRISBURG</u>			
c. LENGTH OF STAY IN 1b <u>Minutes</u>				d. STREET ADDRESS <u>2311 N. FRONT ST.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 111 1 Mi. South of Parkton</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>L.</u> Last <u>Levi</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13, 1906</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Levi</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Block</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>446 26 0991</u>		17. INFORMANT <u>R. J. Reese</u> <u>911 N. Second St., Harrisburg, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest</u> <u>819X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>TIME OF DEATH</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto mobile accident</u> <u>Station wagon crashed into bridge abutment</u>					
20c. TIME OF INJURY Hour <u>4</u> p. m. <u>9/24</u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 111</u>		20f. (City or town) <u>HARRISBURG</u> (County) <u>MD.</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9/24/61</u>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 27, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth El Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Paxtang, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>DATE P 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a preliminary certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11M3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



9951

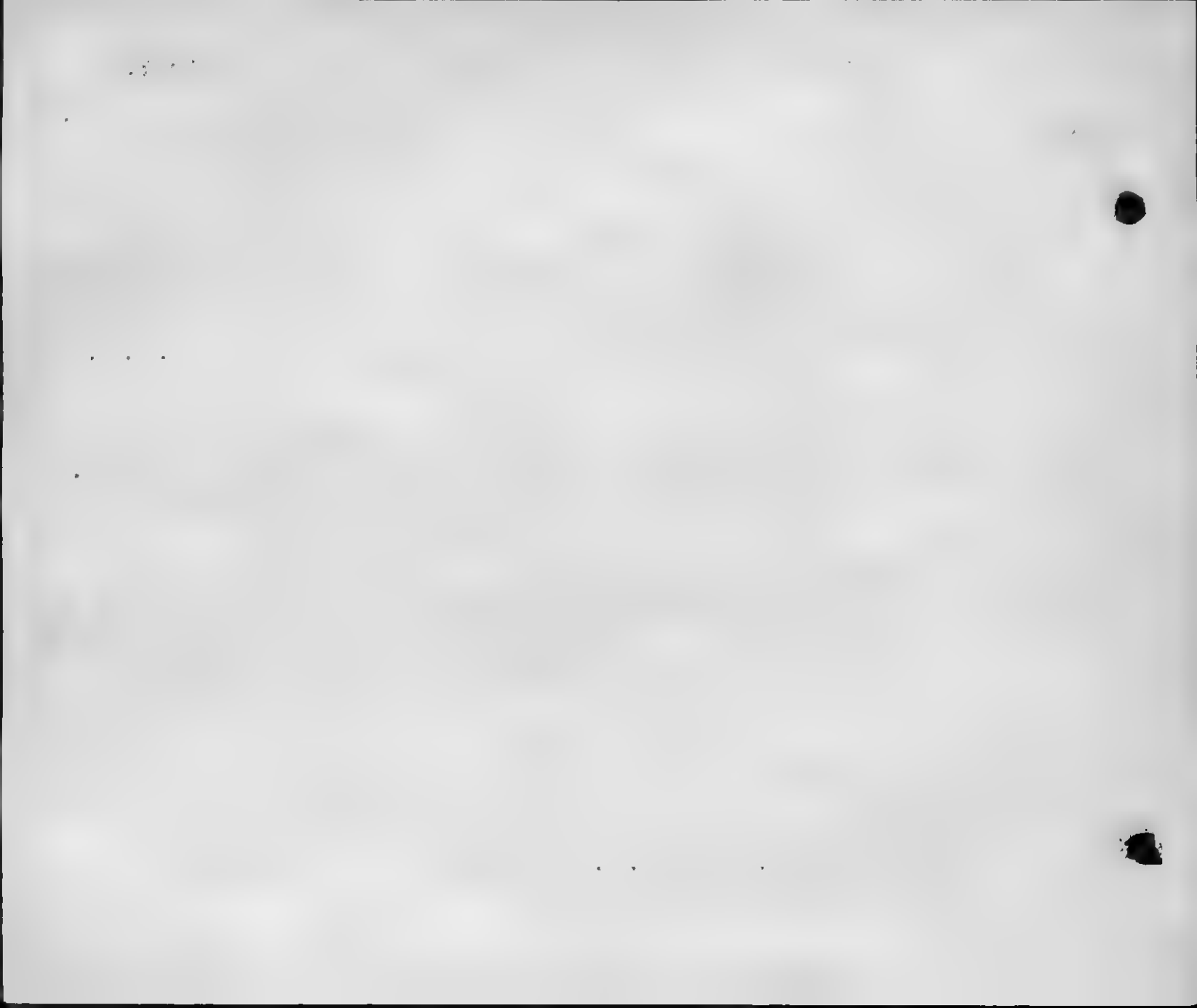
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09942

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the above information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, before admission) a. STATE Maryland		b. COUNTY Prince Geo.	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b. 3 days		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Lanham, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 8805 Courtland Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BEATRICE		First Middle Last LEWIS		4. DATE OF DEATH Month Day Year 9 11 1961	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY unknown		8. DATE OF BIRTH April 11, 1893	
13. FATHER'S NAME Henry Saunders		14. MOTHER'S MAIDEN NAME unknown		9. AGE (In years last birthday) 68 yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		11. BIRTHPLACE (State or foreign country) New Jersey	
17. INFORMANT unknown		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis - broncho-pneumonia, complicating DUE TO (b) Psychosis due to cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) RECORDS: Spring Grove State Hospital		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
22f. (City or town) 19		22g. (County) 19		22h. (State) 19	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Russell S. Fisher, M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/11/61	
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Md		22d. LOCATION (City, town, or country) 19	
23. FUNERAL DIRECTOR Francis Gaschi Sons Hyattsville Md		24a. REC'D BY REGISTRAR SEP 13 '61		24b. REGISTRAR'S SIGNATURE Walter S. Thomas	



151
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9952

CERTIFICATE OF DEATH

09944

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u> c. LENGTH OF STAY IN b <u>60 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PAINTER'S MILL ROAD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u> d. STREET ADDRESS <u>PAINTERS MILL ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE BOULLEMET LIMERICK</u> First Middle Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>AUGUST 17, 1878</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>83</u> yrs. 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEVER EMPLOYED</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country) <u>NEW ORLEANS, LOUISIANA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROLAND H. BOULLEMET</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		14. MOTHER'S MAIDEN NAME <u>CAROLINE BUCKLEY</u> 16. SOCIAL SECURITY NO <u>Mrs I.C. LYCETT</u> 17. INFORMANT <u>ABOVE</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4-20.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic & hypertensive</u> (a), stating the underlying cause last. DUE TO (c) <u>arterio-sclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>10 years</u> <u>2 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 29</u> ..., 19 <u>61</u> to <u>Sept 4</u> ..., 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 4</u> ..., 19 <u>61</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Palmer F.C. Williams</u> 22c. PHYSICIAN'S NAME (Type) <u>PALMER F.C. WILLIAMS</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Owings Mills, Md.</u>	
22b. DATE SIGNED <u>Sept 5 '61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept 6, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. JENKINS & SONS</u> ADDRESS <u>4905 YORK ROAD BALT 12</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles L. Harris</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

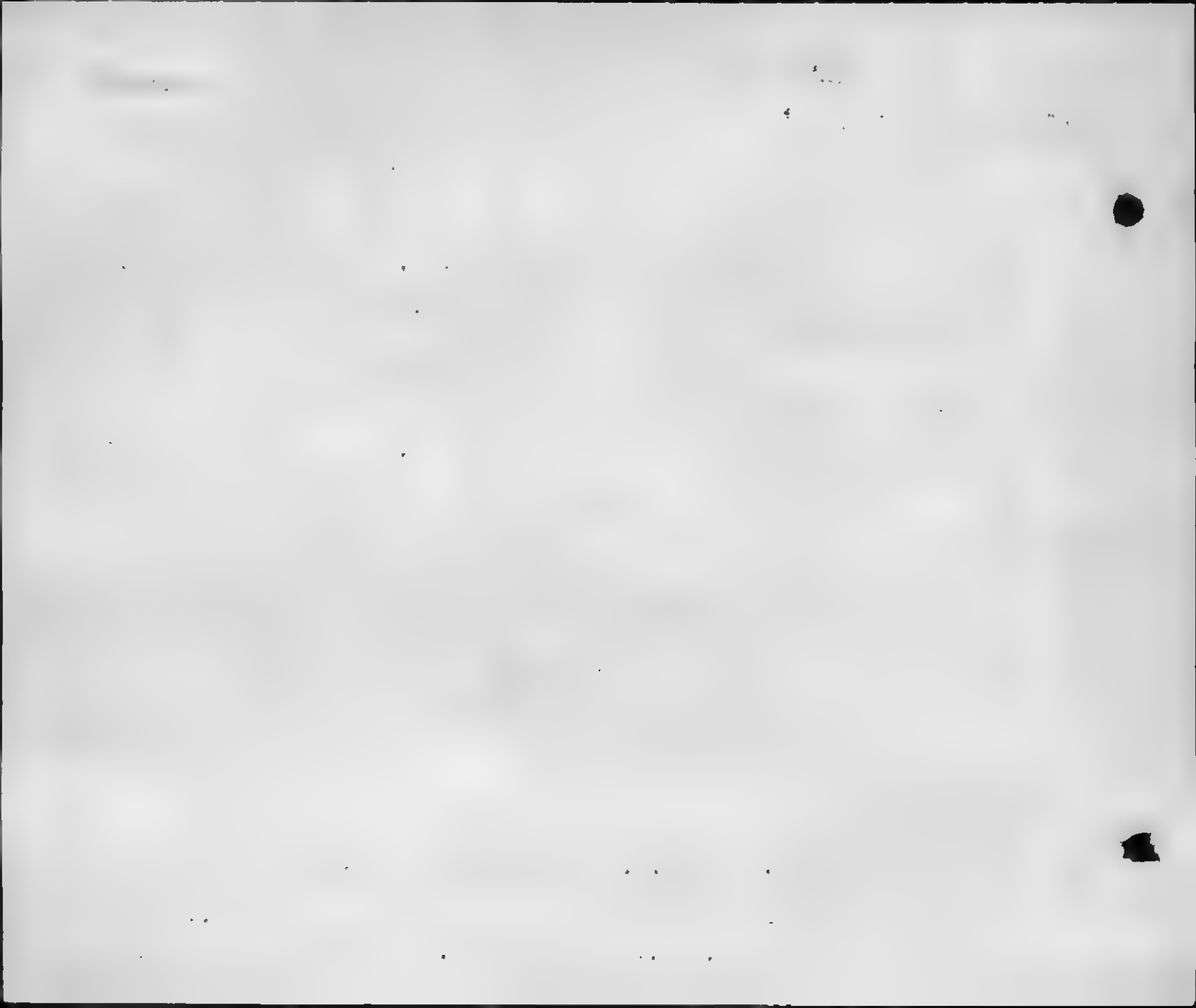
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09945

1
FOR STATE HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21) c. LENGTH OF STAY in 1b 419 Eastern Avenue d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WALTER +++ LUEDECKE, Sr.		2. USUAL RESIDENCE (Where deceased lived, if institution residence, give institution) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22) d. STREET ADDRESS 2983 Cornwall Road		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER		4. DATE OF DEATH September 22, 19 61		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 14, 1894	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Canada	
13. FATHER'S NAME John Luedecke		14. MOTHER'S MAIDEN NAME Anna (Unknown)		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Elizabeth K. Luedecke		17. INFORMANT same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) A-s-c-v Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) No			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dundalk, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M B Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/23/61	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md.		22d. LOCATION (City, town, or country) Baltimore Co., Maryland		24a. REC'D BY REGISTRAR SEP 25 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Harris			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

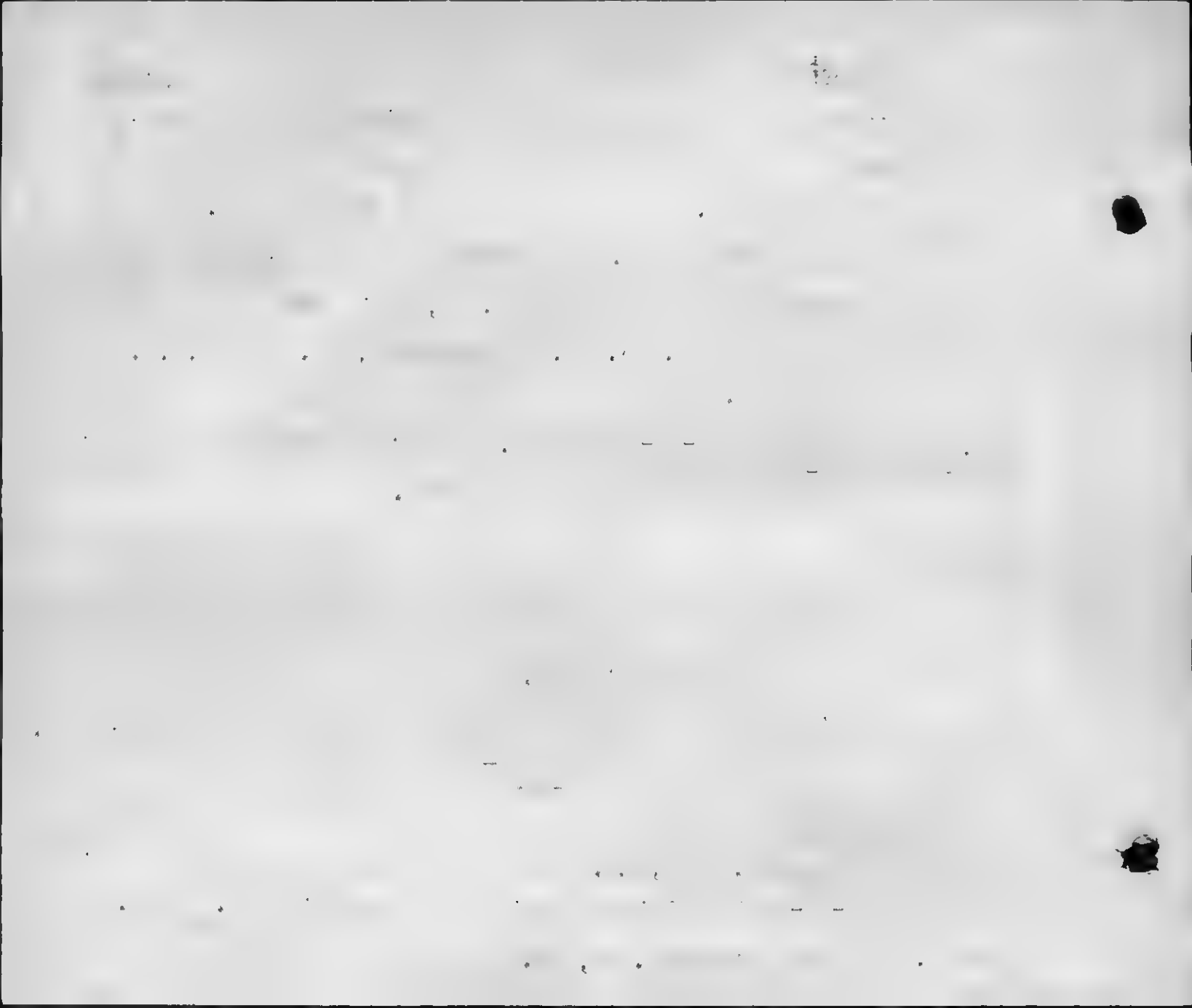
FOR STATE HEALTH DEPT.

0954

09946

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1757 Brookview Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 1757 Brookview Rd.	
3. NAME OF DECEASED (Type or print) ROBERT W. LUPTON 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1917 9. AGE (In years, months, days) 43 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman 10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Md. 11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert J. Lupton 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, Marine Corps 16. SOCIAL SECURITY NO. 218-01-6199		14. MOTHER'S MAIDEN NAME Lottie Romoser 17. INFORMANT Mrs. Catherine Lupton Address 1757 Brookview 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact Gunshot Wound of Head. 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 9/17 19 61 Hour xx 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) Home 20f. (City or town) Dundalk (County) Baltimore (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i> EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/17/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-20-1961		22c. NAME OF CEMETERY OR CREMATORY Baltimore National 22d. LOCATION (City, town, or country) Frederick Rd. Md.	
23. FUNERAL DIRECTOR JOHN J. DUDA ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR SEP 21 '61 24b. REGISTRAR'S SIGNATURE <i>William S. Kneass</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



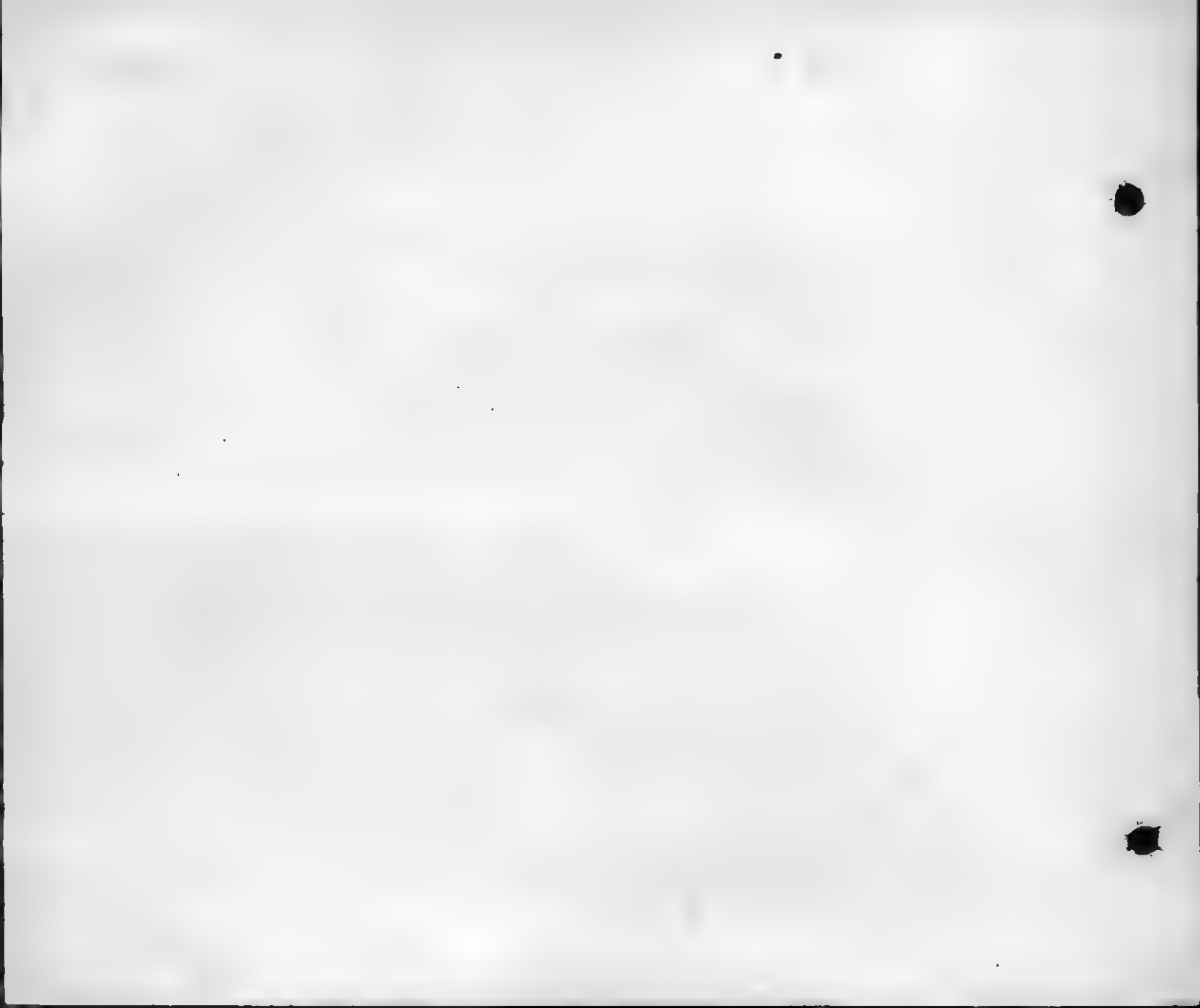
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9955

09947

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>—</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>2 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Baltimore</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Joseph J. Machovec</i>		4. DATE OF DEATH Month Day Year <i>Sept. 27, 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 8, 1887</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurantier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>FRANK Machovec</i>		14. MOTHER'S MAIDEN NAME <i>FRANCES ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-32-8960</i>	
17. INFORMANT <i>MRS. AGNES MACHOVEC</i>		Address <i>1931 GRINNARD'S</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>3-1X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>August 1961</i> to <i>Sept 27, 1961</i> that (I) (we) last saw the deceased alive on <i>Sept 26, 1961</i> and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Justinas Kudirka</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Justinas KUDIRKA</i>		22d. ADDRESS <i>1709 Edmonson Ave, Catonsville</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>9/30/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Washington Blvd. Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>George L. Schwanke Jr.</i>		ADDRESS <i>2101 Frederick Ave</i>	
25a. REC'D BY REGISTRAR <i>OCT 2 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krawe</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

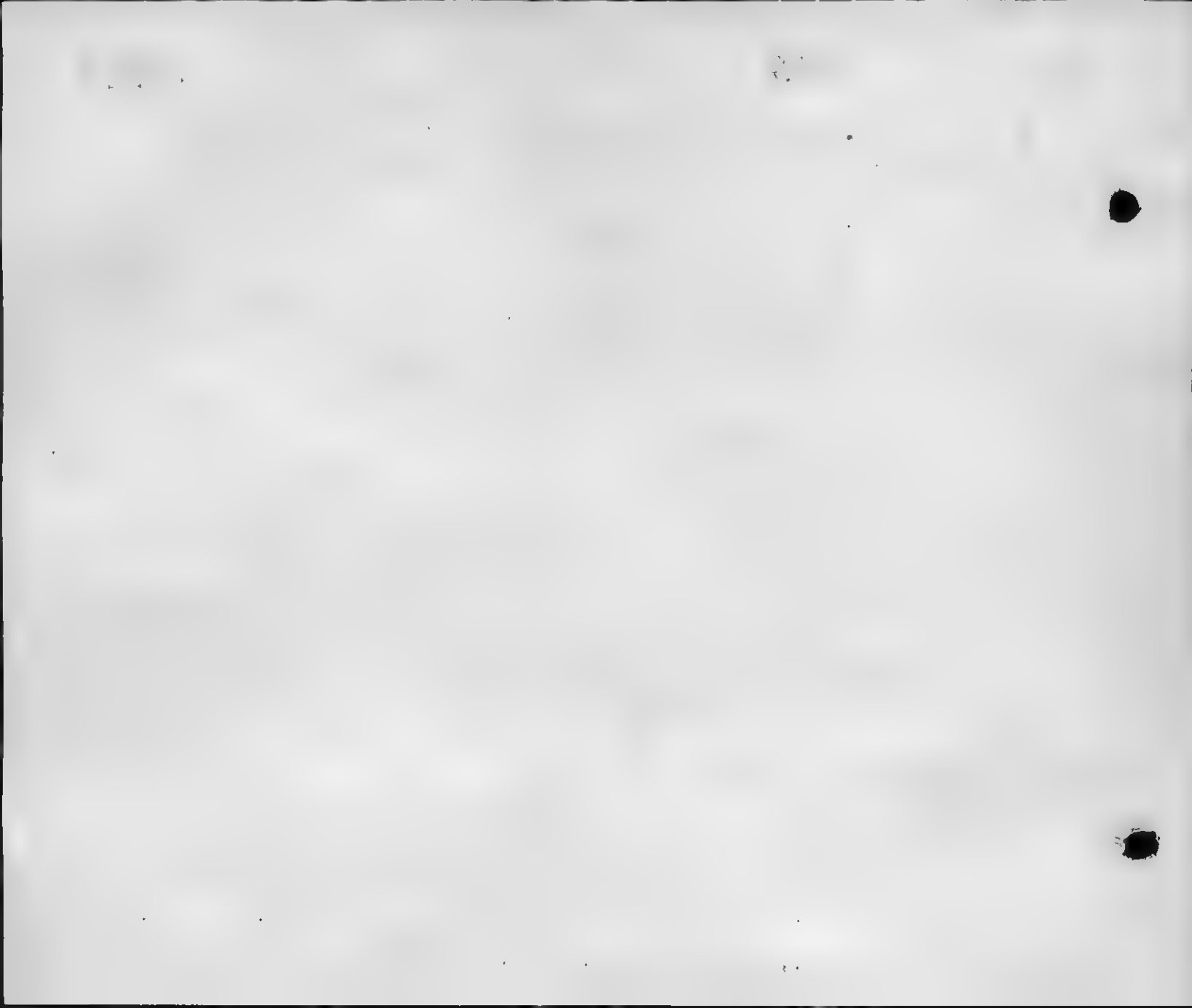
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9955

CERTIFICATE OF DEATH

09948

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oak Grove Apts.</u> d. STREET ADDRESS <u>3 Oak Grove Drive</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oak Grove Apts.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>OAK GROVE APTS. - 3 Oak Grove Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u>		4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Feb. 6, 1867</u>		8. AGE (In years, last birthday) <u>94</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11. PLACE OF BIRTH (County & State, or foreign country) <u>Great Britain, Newfoundland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Stephen Moulton</u>	
14. MOTHER'S MAIDEN NAME <u>Mr. Edgar L. Marsh, 3 Oak Grove Drive, Balto. Co.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT (son) <u>Mr. Edgar L. Marsh, 3 Oak Grove Drive, Balto. Co.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio-sclerotic cerebro-vascular disease</u> DUE TO (c) <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 days</u> INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2108 OREMS RD. BALTO. MD.</u>		20f. (City or town) (County) (State) <u>BALTO. MD.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>Sept. 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 6, 1961</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis Semenovff</u>		22b. DATE SIGNED <u>9/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>		22d. ADDRESS <u>2108 OREMS RD. BALTO. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 9, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Roslyn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Roslyn, L. I., N. Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>STEWART & MOWEN CO. 10 7. North Av., Balto. 1</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

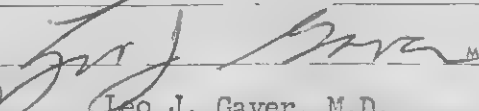


MARYLAND STATE DEPARTMENT OF HEALTH

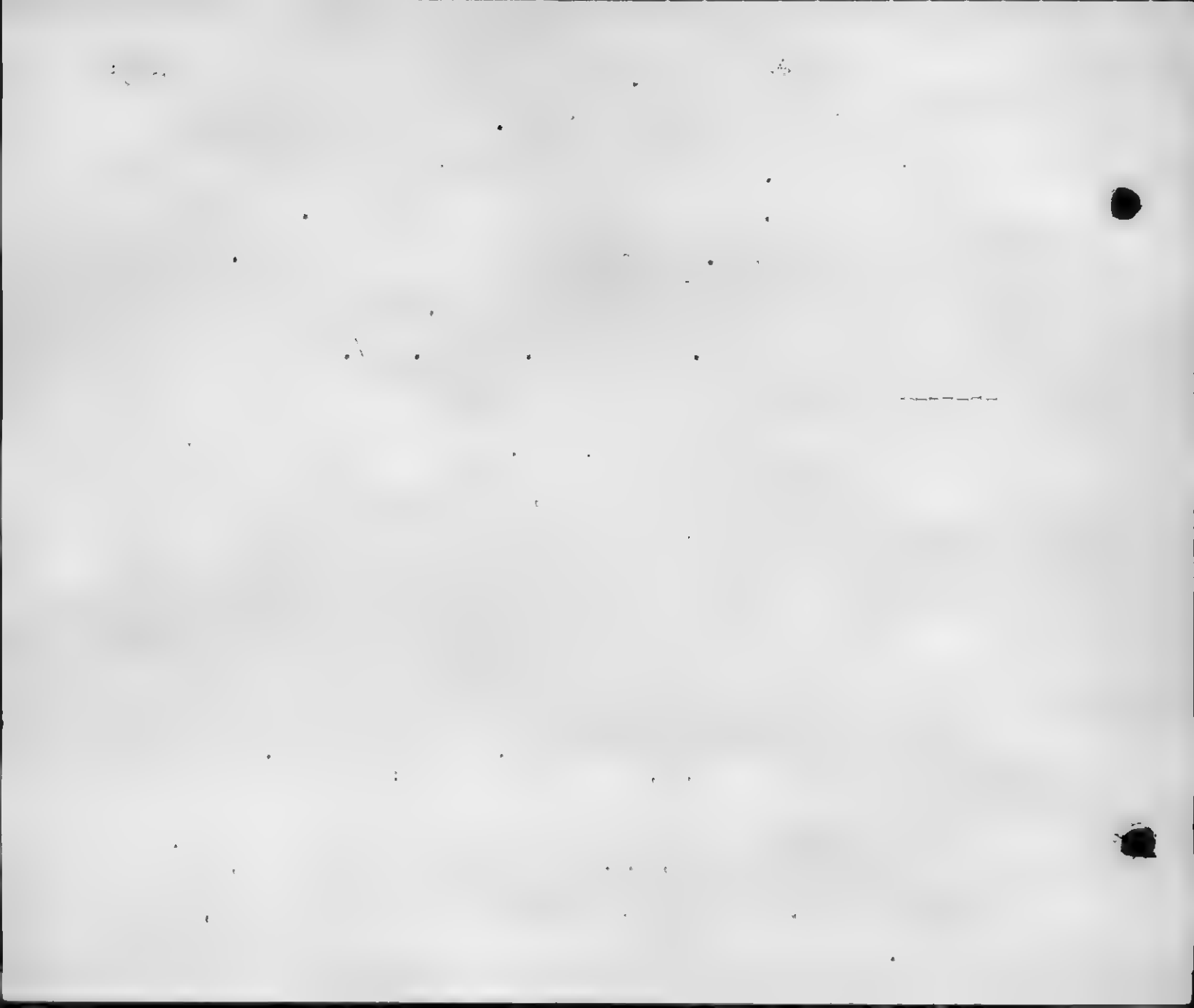
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9957

09949

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 405 Overbrook Rd.		d. STREET ADDRESS 405 Overbrook Rd.	
3. NAME OF DECEASED (Type or print) Charles L. McConnell		4. DATE OF DEATH Sept. 14/61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1884
9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Md. Biscuit Co. Balto. Md.	
13. FATHER'S NAME McConnell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213 09 6839	
17. INFORMANT Mrs. Marie McConnell		Address 405 Overbrook RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-vascular Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Oct. 1960, to Sept. 1961 , that (I) (we) last saw the deceased alive on Sept. 9, 1961 , and that death occurred at 5:10 PM from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 9/15/61	
22c. PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.		22d. ADDRESS 1 Mallow Hill Ave., Baltimore 29, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 18/61	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City, town or county) (State) Baltimore 29, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave		25a. REC'D BY REGISTRAR DATE SEP 22 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

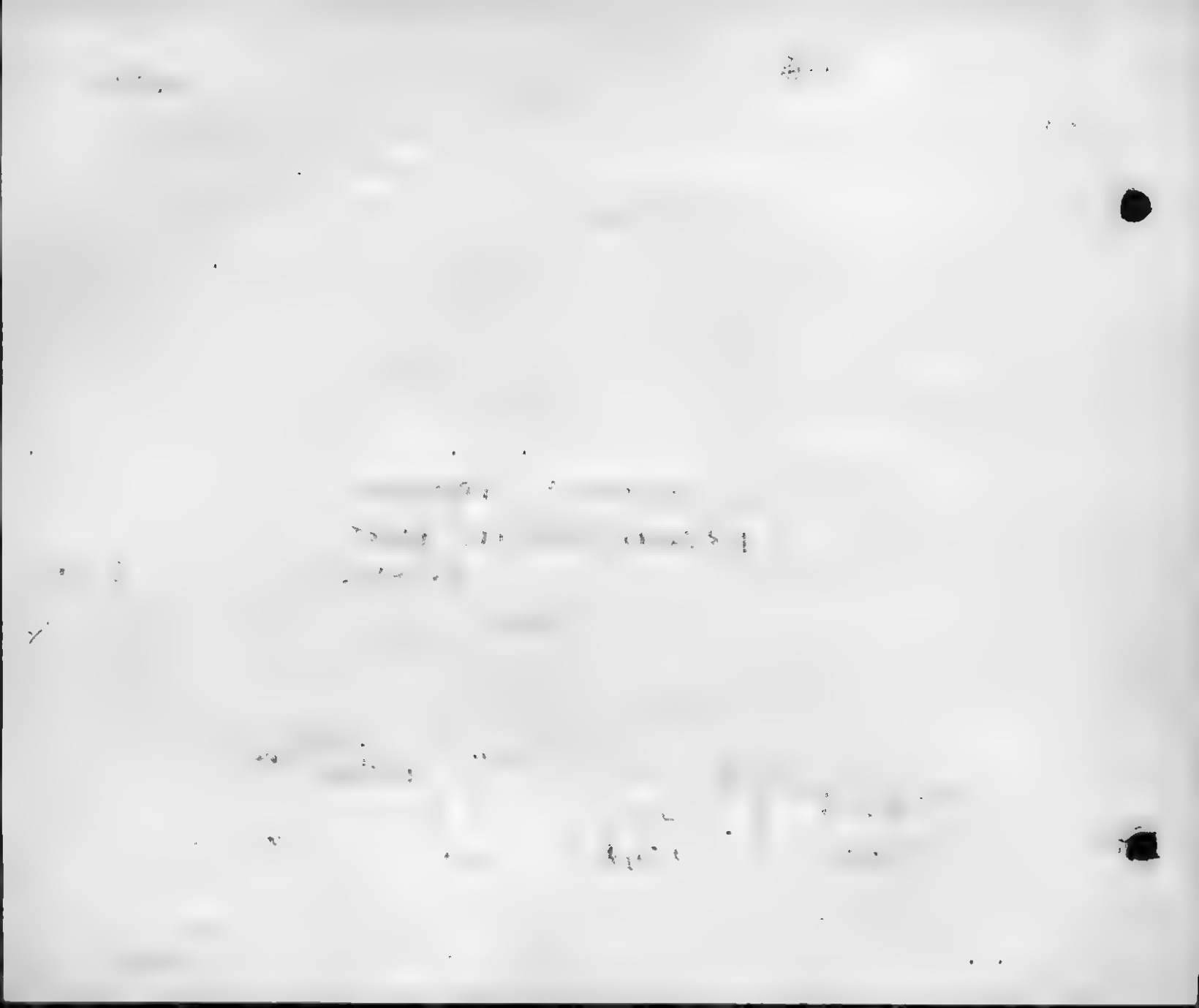
9958

09958

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>115 Shetland Hills Drive</u>		d. STREET ADDRESS <u>803 Wellington Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u>		Last <u>McDaniel</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1886</u>		9. AGE (In years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Emil Dorman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-7993</u>		17. INFORMANT <u>Mrs. w. J. Steele 115 Shetland Hills Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CAUSE OF FAILURE</u> Conditions, if any, which gave rise to immediate cause (b) <u>MYOTONIC DYSTROPHY</u> (a), stating the underlying cause last. (c) <u>DISINTEGRATION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4725</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> to <u>9/14</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> , and that death occurred at <u>10:15 PM</u> on the causes and on the date stated above.					
22a. SIGNATURE <u>Stewart D. Soudky</u>		22b. ADDRESS <u>201 E. 39th St.</u>		22c. PHYSICIAN'S NAME <u>Stewart D. Soudky</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-18-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	
23d. LOCATION (City, town or county) <u>Parkville</u>		(State) <u>Md.</u>		25a. REC'D BY REGISTRAR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto</u>	
25b. REGISTRAR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>		DATE <u>SEP 18 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

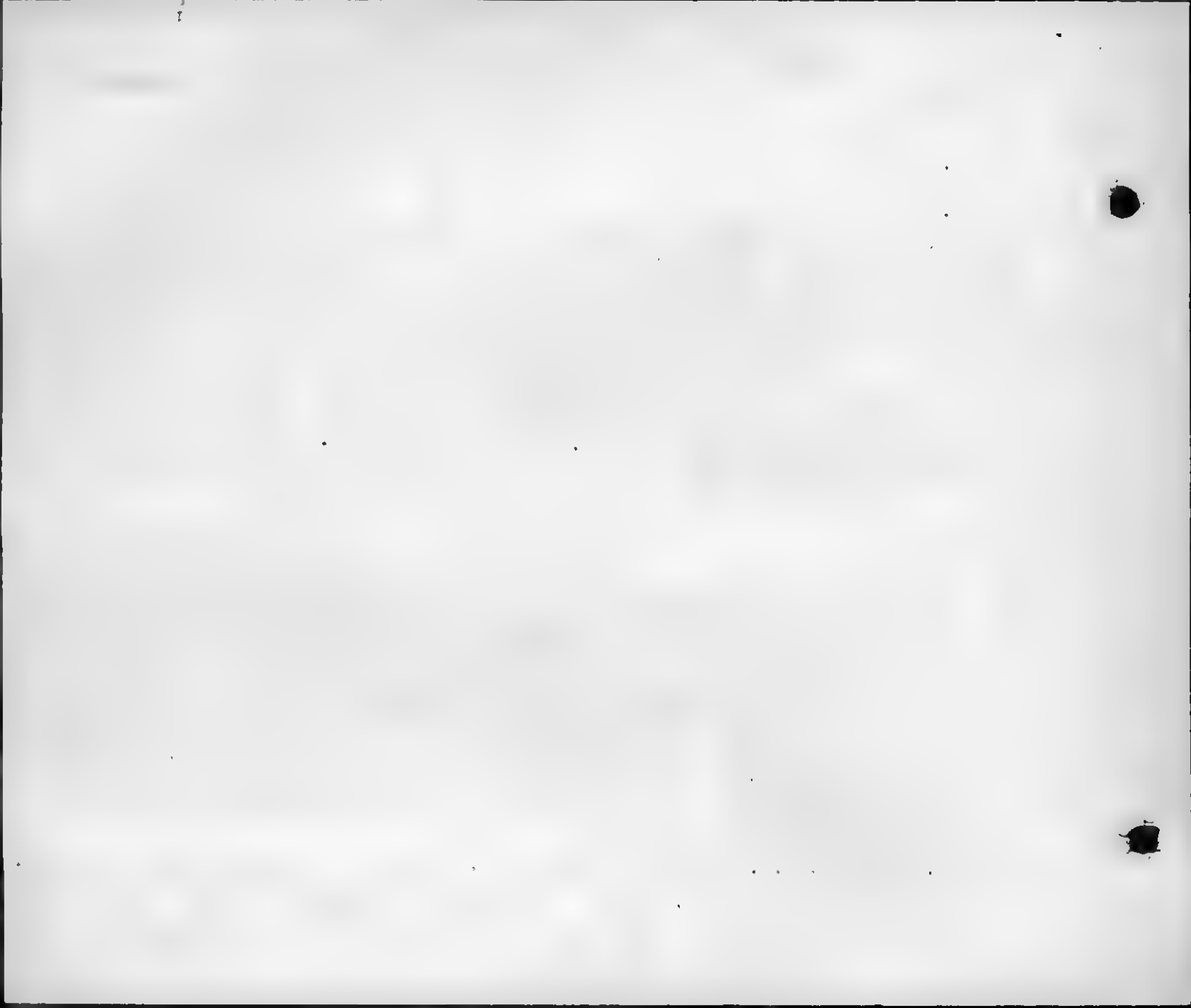
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Wilson, Maryland c. LENGTH OF STAY IN 1b 3 mo. 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4018 Gelston Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Timothy McLaughlin First Middle Last		4. DATE OF DEATH Month 9 Day 26 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/05
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. McLaughlin		14. MOTHER'S MAIDEN NAME Mary A. Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-5718	
17. INFORMANT Hospital Records, St. Wilson State Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Mouth 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 13 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Advanced Pulmonary Tuberculosis		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) X	
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/19 1961 to 9/26 1961 that (I) (we) last saw the deceased alive on 9/26 1961 and that death occurred at 2A M, from the causes and on the date stated above.			
22a. SIGNATURE W. Newcomer M.D.		22b. DATE SIGNED 9/26/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny Inc - Balto Md ADDRESS		25a. REC'D BY REGISTRAR SEP 29 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9960

09952

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>14 Ridge Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Isabel Meehan</u>		4. DATE OF DEATH Month Day Year <u>September 16 1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19--1883</u>	
9. AGE (In years, last birthday) <u>78</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Hannan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Clarke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Elizabeth Sima, 14 Ridge Rd; Catonsville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Respiratory failure</u> (b) <u>Dehydration & malnutrition</u> (c) <u>Septicemia, chronic cholecystitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombocytopenia purpura</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1961, to 16 Sept 1961 that (I) (we) last saw the deceased alive on 16 Sept 1961, and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>William J. Ryan</u>		22b. DATE SIGNED <u>18 Sept 61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-19-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		23d. LOCATION (City, town or county) (State) <u>Howard County-Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. S. Max, Natl. Jr.</u>		25a. REC'D BY REGISTRAR <u>SEP 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		25c. ADDRESS <u>Catonsville, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



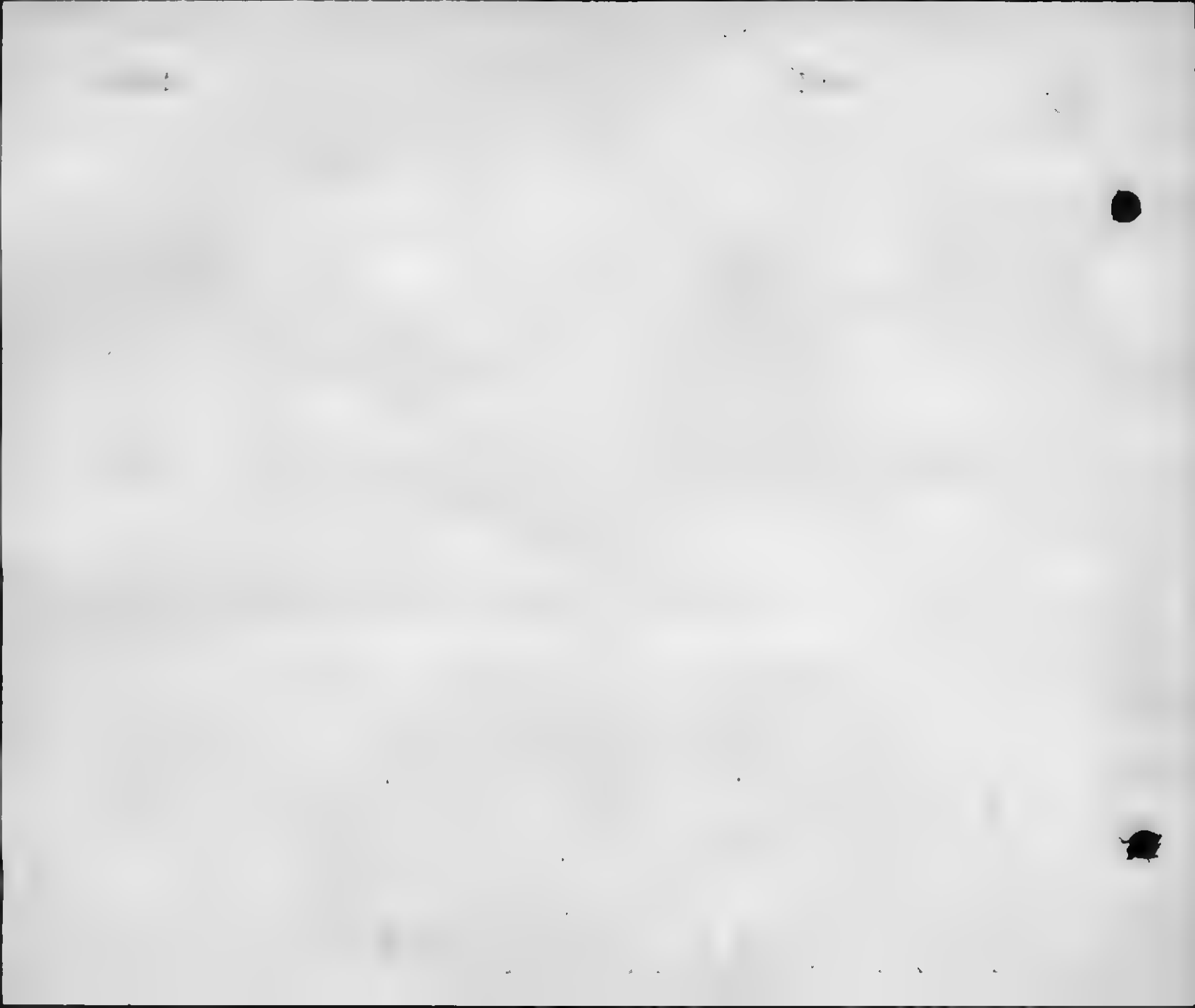
CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN TB 7yr8mth10 dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Maryland d. STREET ADDRESS Sheriff Road	
3. NAME OF DECEASED (Type or print) Carrie First Middle Last Megill		4. DATE OF DEATH Month Day Year September 12 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1879 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 2 1954 to Sept. 12 1961 , that (I) (we) last saw the deceased alive on Sept. 12 1961 , and that death occurred at p.m. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D. 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22b. DATE SIGNED 9-13-61 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL (CREMATION, REMOVAL) (Specify) 9-14-61	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Lee's Cemetery	23d. LOCATION (City, town or county) (State) Washington D.C.
24. FUNERAL DIRECTOR'S SIGNATURE Free Funeral Home Wash. D.C.		25a. REC'D BY REGISTRAR SEP 18 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kneap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

9962

09954

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Reside <u>09954</u>) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 24</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>7007 FAIT AVE</u>		d. STREET ADDRESS <u>7007 FAIT AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elmer David Melton Sr</u>		4. DATE OF DEATH Month Day Year <u>Sept 29 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 16, 1901</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Columbus David</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Lee Mickey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Navy</u> If yes, give war or dates of service		16 SOCIAL SECURITY NO. <u>213-074194</u>	
INFORMANT <u>MRS ETIA MELTON-7007 FAIT AVE.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1960</u> to <u>Sept 29, 1961</u> , that I last saw the deceased alive on <u>Sept 29, 1961</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronald Berger</u>		DATE SIGNED <u>9/29/61</u>	
PHYSICIAN'S NAME (Type) <u>ULLRICH FUNERAL HOME - 4210 BELMONT</u>		ADDRESS	
22a BURIAL, CREMATION OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/2/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>OVERLEA MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>William E. Kenna</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. D 4 9955

1. PLACE OF DEATH
a. COUNTY *Baltimore* MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Rural-Parkton*
c. LENGTH OF STAY IN 1b *50 yrs*
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *Miller Lane*

2. USUAL RESIDENCE (Where deceased lived. If institut on, Residence before admission)
a. STATE *Md.*
b. COUNTY *Baltimore*
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Rural-Parkton*
d. STREET ADDRESS *Miller Lane*
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)
First *Hester* Middle *I.* Last *Miller*

4. DATE OF DEATH
Month *September* Day *4* Year *1961*

5. SEX *F* 6. COLOR OR RACE *W* 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH *Dec 17 1887* 9. AGE (in years last birthday) *73* yrs. IF UNDER 1 YEAR: Months *7* Days *13* Hours *13* Min *13*

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Housewife* 10b. KIND OF BUSINESS OR INDUSTRY *Freeland, Md* 11. BIRTHPLACE (State or foreign country) *U.S.A.* 12. CITIZEN OF WHAT COUNTRY? *U.S.A.*

13. FATHER'S NAME *Absolom Baker* 14. MOTHER'S MAIDEN NAME *Frances Turnbaugh*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *No* 16. SOCIAL SECURITY NO. *—* 17. INFORMANT *Fred S. Miller, Parkton, Md.* Address *—*

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Coronary Occlusion*
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) *Coronary sclerosis* DUE TO
(c) *3 yrs*

INTERVAL BETWEEN ONSET AND DEATH *3 yrs*

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *Hypertensive Congestive Heart disease* 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. *19* p.m. *19* 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from *5-14-*, 19*56* to *9-4-*, 19*61*, that I last saw the deceased alive on *8-30-*, 19*61*, and that death occurred at *3:30 P.M.* from the causes and on the date stated above.

ACTUAL SIGNATURE *Paul D. Shaub* ADDRESS (Street, city or town, state) *Shrewsbury, Pa.* DATE SIGNED *9-6-61*

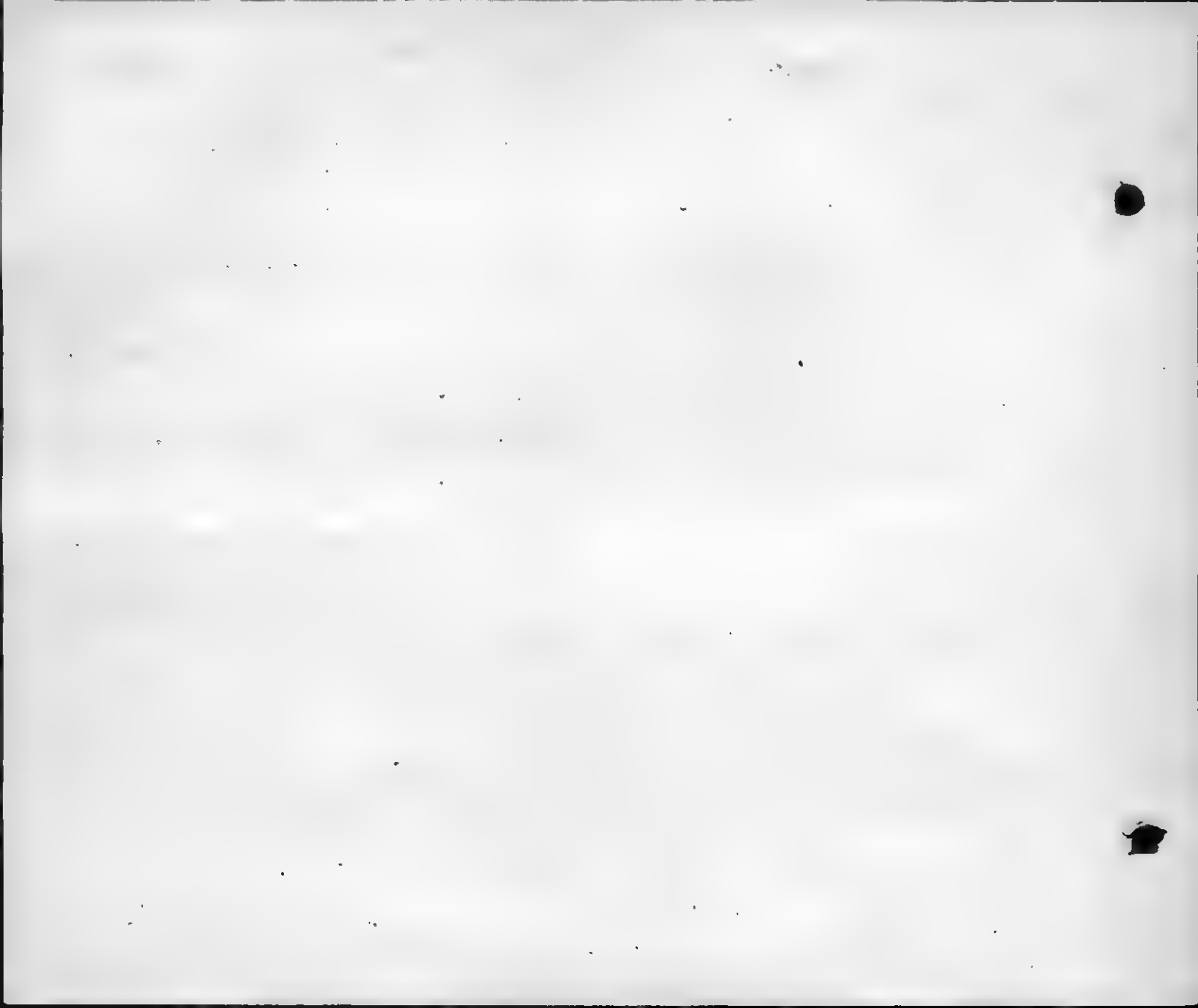
PHYSICIAN'S NAME (Type) *Paul D. Shaub* *Shrewsbury, Pa.*

22a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 22b. DATE THEREOF *Sept 7, 1961* 22c. NAME OF CEMETERY OR CREMATORY *Wiseburg Cemetery* 22d. LOCATION (City, town or county) (State) *White Hall, Md.*

23. FUNERAL DIRECTOR'S SIGNATURE *Jacob Hartenstein* ADDRESS *New Freedom, Pa.* 24a. REC'D BY REGISTRAR *SEP 11 '61* 24b. REGISTRAR'S SIGNATURE *William S. Kiana*

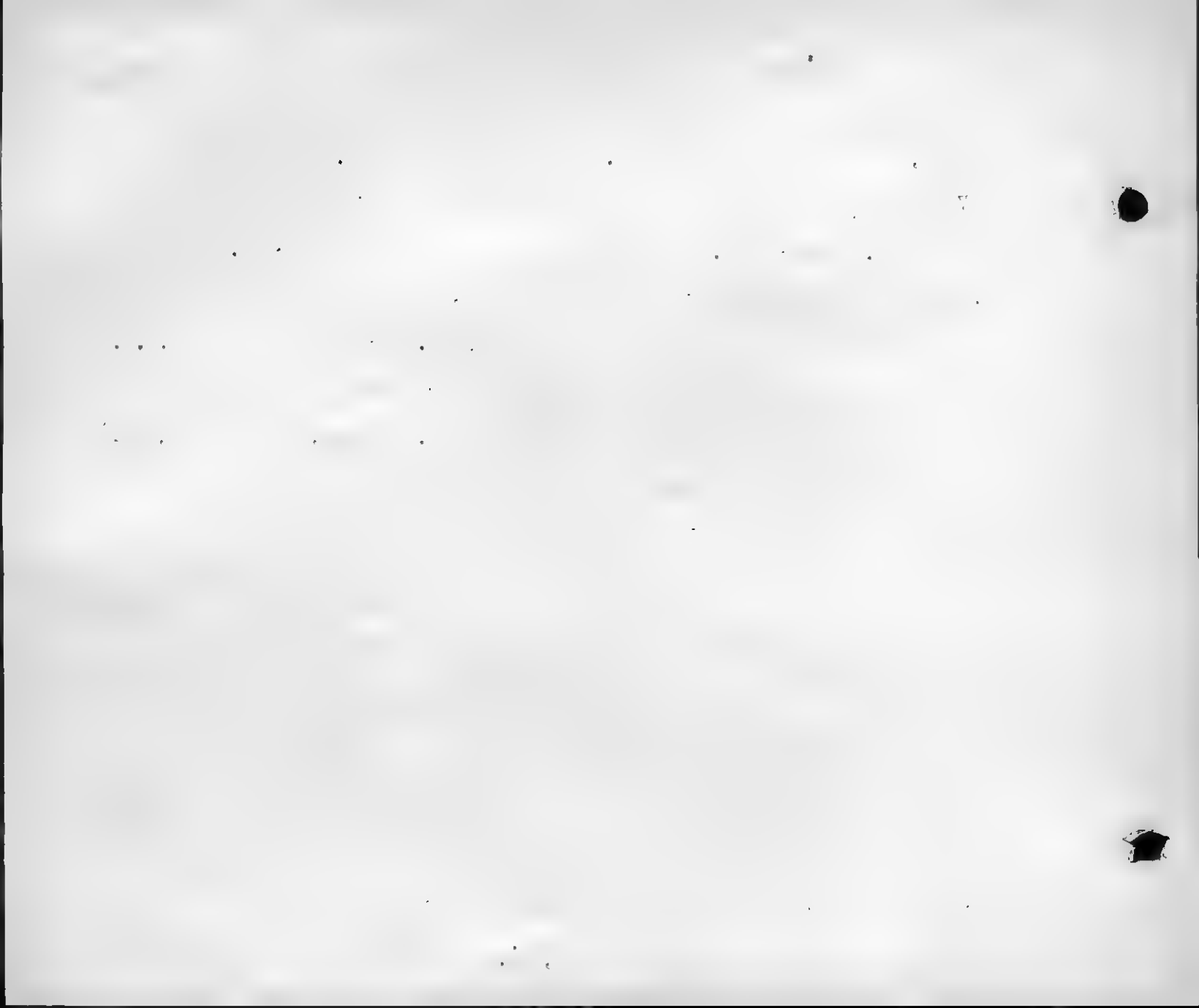
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 9964
 CERTIFICATE OF DEATH
 09956

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, 4		c. LENGTH OF STAY IN lb 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8170 Glen Gary Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Catharine A. Monaghan		4. DATE OF DEATH Month Day Year Sept. 21 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1884
9. AGE (In years last birthday) yrs. 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Balto. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Malachy Lyons	
14. MOTHER'S MAIDEN NAME Margaret Wynn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Marie B. Monaghan, Baltimore 4, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic pneumonia 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arterio-sclerosis (Generalized) DUE TO (c) Diabetes			INTERVAL BETWEEN ONSET AND DEATH 45 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct-10, 1956 to Sept 21, 1961 , that (I) (we) last saw the deceased alive on 9-21-1961 , and that death occurred at 8 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Lee K Fargo		22b. DATE SIGNED 9-21-61	
22c. PHYSICIAN'S NAME (Type) LEE K FARGO MD		22d. ADDRESS 8151 LOCH RAVEN BLVD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-25-61	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Young Byers		25a. REC'D BY REGISTRAR SEP 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Knepp		25c. ADDRESS 8728 Liberty Rd. Randallstown, Md.	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
9965		09957	
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; otherwise, last residence) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 1 Day		d. STREET ADDRESS 118 N. Carlton Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE		4. DATE OF DEATH September 9 19 61	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1893	
9. AGE (in years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (Country & State, or foreign country) Darlington S. Carolina		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Ervin Muldrow		14. MOTHER'S MAIDEN NAME Jane Barry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-05-7265	
17. INFORMANT Clinical Records, VAH, FORT HOWARD DIVISION		Address Baltimore 18, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. XXXXXXXXXX (c) HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. City or town (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 8 19 61 to September 9 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 9 19 61 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Crahan 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.	
22b. DATE SIGNED 9/11/61		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR SEP 15 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS 1000 Brantley Ave. Baltimore 17, Maryland	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
20662 **CERTIFICATE OF DEATH**

2966

09958

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; otherwise, address on a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6611 Frederick Ave</u>		d. STREET ADDRESS <u>16611 Frederick Ave</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM E NICHALSON</u>		4. DATE OF DEATH <u>Sept 22 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/83</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-09-0354</u>	
17. INFORMANT <u>Margaret Phillips</u>		Address <u>16611 Frederick Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u>		DUE TO <u>Coronary Artery Disease</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcific Aortic Stenosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 9/10</u> , 19 <u>61</u> , to <u>9/22</u> , 19 <u>61</u> , that (I) (we) saw the deceased alive on <u>9/10</u> , 19 <u>61</u> , and that death occurred at <u>12:00</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James Nolan</u>		22b. DATE SIGNED <u>9/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J S NOLAN</u>		22d. ADDRESS <u>Baltimore 39, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Toddington Park</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Max Miller & Son</u>		25a. REC'D BY REGISTRAR <u>28</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>SEP 26 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9967

09959

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>1440</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2133 Eagle St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <u>HERBES M. NIESZ</u>		4. DATE OF DEATH Last <u>9</u> Month <u>9</u> Day <u>1961</u>	
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 11th 1878</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>CZECHOSLOVAKIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JACOB MILLER</u> 14. MOTHER'S MAIDEN NAME <u>ELIZABETH DUGANZAK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Spring Grove State Hospital Records</u> Address _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic brain syndrome assoc. with syphilis; meningo-encephalitis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> 19 <u>47</u> to <u>9/9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> 19 <u>61</u> , and that death occurred <u>9/30</u> AM , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bruno Radauskas</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		22b. DATE SIGNED <u>9/9/61</u> 22d. ADDRESS <u>Spring Grove St. Hosp. Catonsville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/12/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u> 23d. LOCATION (City, town or county) <u>3801 Frederick Ave</u> (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Courtenay</u> ADDRESS <u>9 Hollins St.</u> 25a. REC'D BY REGISTRAR <u>SEP 11 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

100



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9968

Reg. Dist. No. 99960

1. PLACE OF DEATH a. COUNTY BALTO. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO COUNTY	
c. LENGTH OF STAY IN 1b 60 YRS		d. STREET ADDRESS 1934 BARDSWELL RD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 934 BARDSWELL RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NORMAN BRANDT NOEL		4. DATE OF DEATH Month Day Year SEPT 4 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY NAT. CAN CO.	
11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME FRANCIS X NOEL		14. MOTHER'S MAIDEN NAME MARY CLUNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W.I.		16. SOCIAL SECURITY NO. 215-09-6005	
17. INFORMANT CATHERINE NOEL		Address 934 BARDSWELL RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 42001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.D. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1951 , to Sept 4, 1961 , that I last saw the deceased alive on Sept 3, 1961 , and that death occurred at 7:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3325 FREDERICK AVE DATE SIGNED 9/5/61 ACTUAL SIGNATURE J. C. POUND M.D. PHYSICIAN'S NAME (Type) J. C. POUND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-8-1961	
22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) 5501 FREDERICK AVE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Weber		ADDRESS 5311 EDMONDSON AVE	
24a. REC'D BY REGISTRAR SEP 6 '61		24b. REGISTRAR'S SIGNATURE Chas. E. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09961

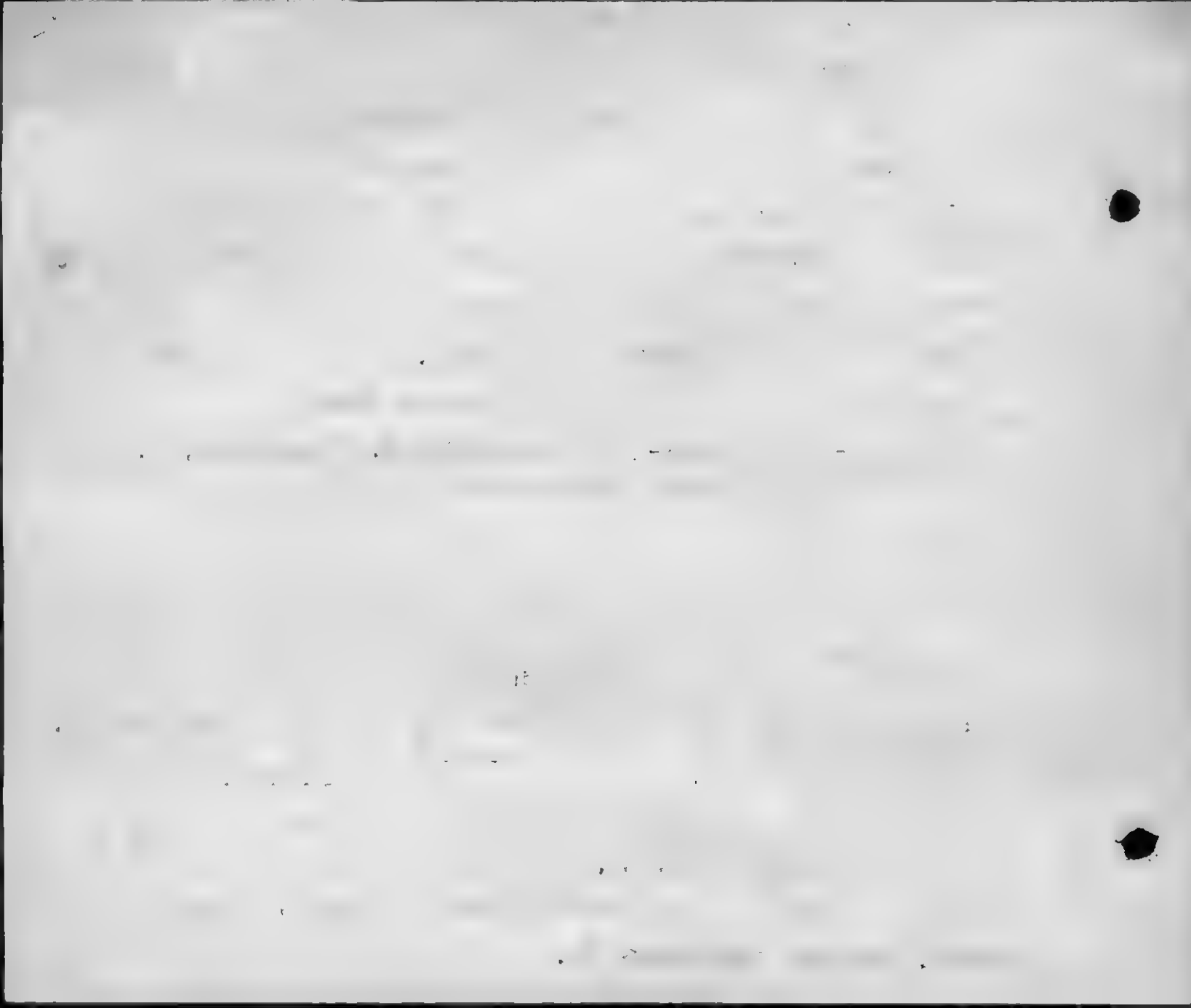
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please contact the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if Institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b Essex (21)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1640A Rickenbacker Road		d. STREET ADDRESS 1640A Rickenbacker Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE		Last NOLAN		4. DATE OF DEATH Month September Day 5 Year 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/16/13		9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edwin Wyadt		14. MOTHER'S MAIDEN NAME Gertrude Knouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 216-10-9515		17. INFORMANT Joseph Nolan Rt. 3 Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Found shot in head			
20c. TIME OF INJURY Month, Day, Year 2:15 a.m. 9/5 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE Howard Shaub		M.D. Howard Shaub, M.D.		DATE SIGNED 9/5/61	
EXAMINER'S NAME (Type) Howard Shaub		Address (Street, city, town, or county) Baltimore, Maryland		22d. LOCAL ON (City, town, or country) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/61		22c. NAME OF CEMETERY OR CREMATORY Lorriane Park Cemetery	
23. FUNERAL DIRECTOR James E. Bruzdinski		Address 1407 Eastern Ave.		24a. REC'D BY REGISTRAR SEP 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Knouse					



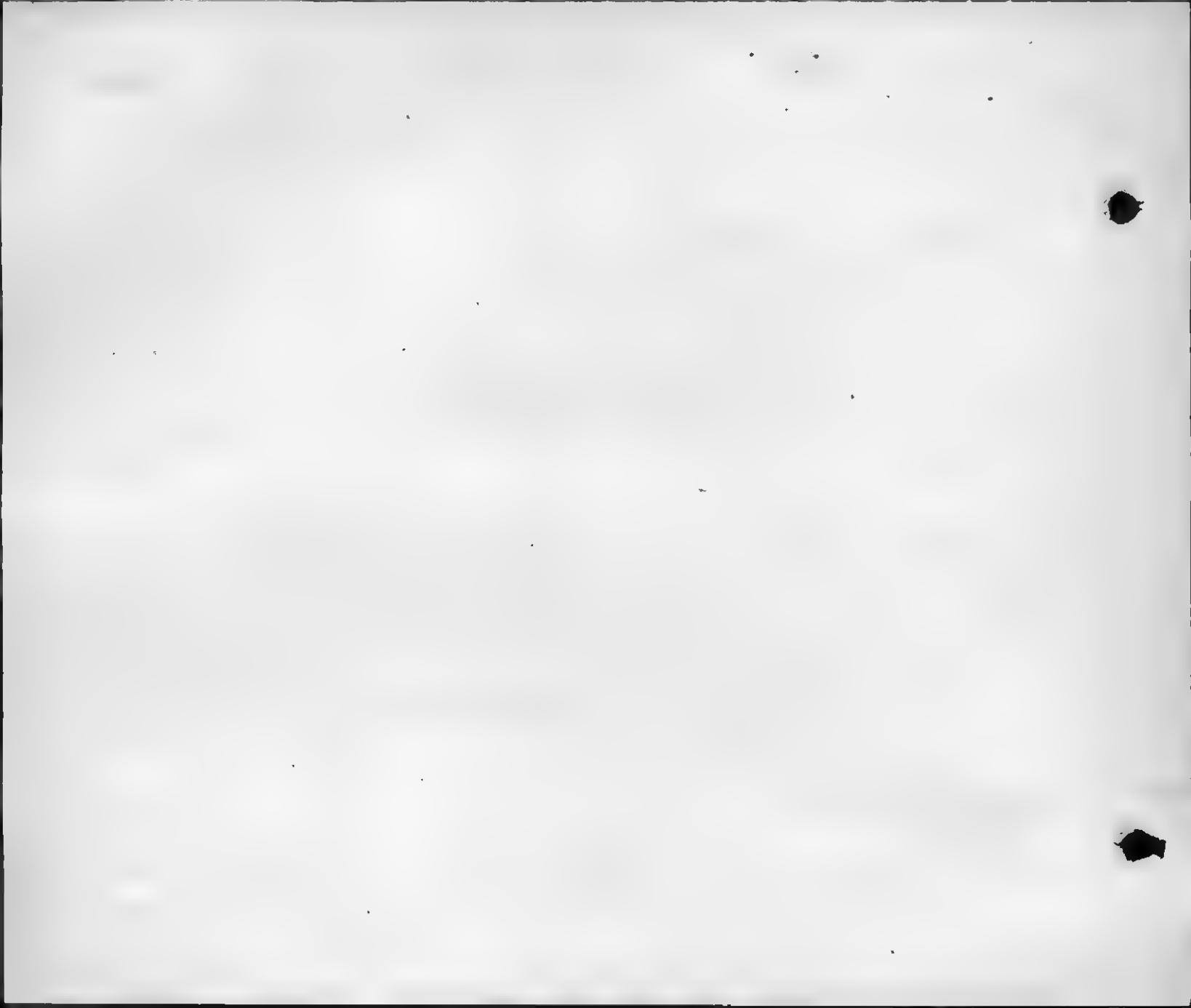
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9970 CERTIFICATE OF DEATH 09962

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 255 Clyde Avenue		d. STREET ADDRESS 255 Clyde Avenue	
3. NAME OF DECEASED (Type or print) First IDA Middle A. Last ODEN		4. DATE OF DEATH Month Sept. Day 25 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1903
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. White		14. MOTHER'S MAIDEN NAME Ida Dutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Tolliver Oden		Address 255 Clyde Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the ovary Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) with metastasis (c) 6 months			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 175.0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1961 to Sept. 25, 1961 , that (I) (we) last saw the deceased alive on Sept. 25, 1961 , and that death occurred about 3 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Hubert L. Levickas		22b. ADDRESS 5305 East Drive	
22c. PHYSICIAN'S NAME (Type) Hubert L. Levickas		22d. ADDRESS 5305 East Drive	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9/28/61	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
25a. REC'D BY REGISTRAR SEP 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

I

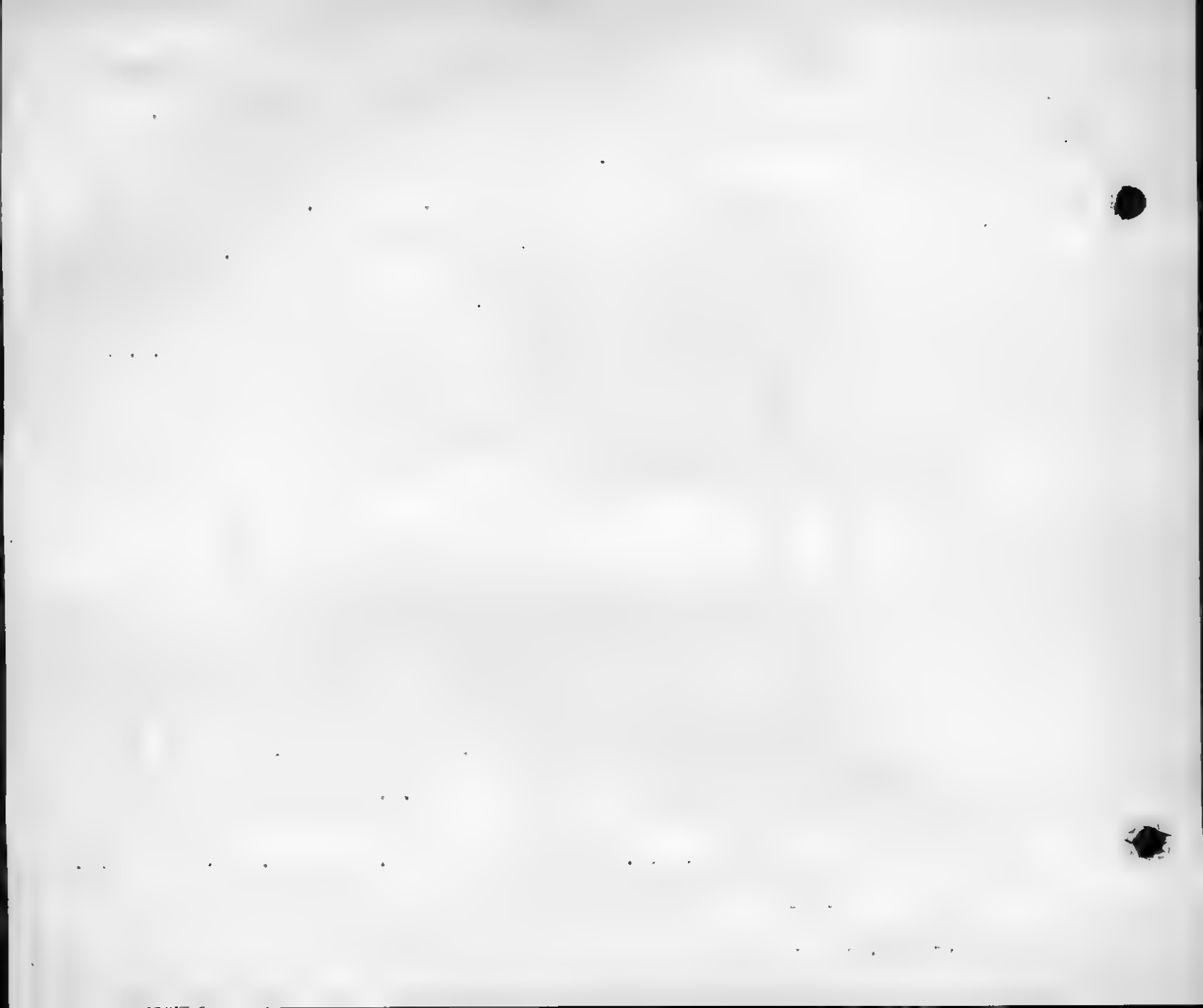
M



1
 MARYLAND STATE BOARD OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 9971
 CERTIFICATE OF DEATH
 09963

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 406 Mt. Holly St.	
3. NAME OF DECEASED (Type or print) First Ida Middle O'Rourke Last O'Rourke		4. DATE OF DEATH Month Sept. Day 20 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/1880
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Knapp		14. MOTHER'S MAIDEN NAME Dora Weber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-32-7729	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Ca - Ad. ov. en. DUE TO Carcinoma, Primary Site Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1960 to Sept. 1961 , that (I) (we) last saw the deceased alive on 9/19/61 , and that death occurred at 9:25 A.M. from the causes and on the date stated above			
22a. SIGNATURE Robert Mahon		22b. DATE SIGNED SEP 25 '61	
22c. PHYSICIAN'S NAME (Type) Robert Mahon, M.D.		22d. ADDRESS 602 E. Joppa Rd. Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-23-61	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc., 1050 York Road, Towson		25a. REC'D BY REGISTRAR DATE SEP 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

9972

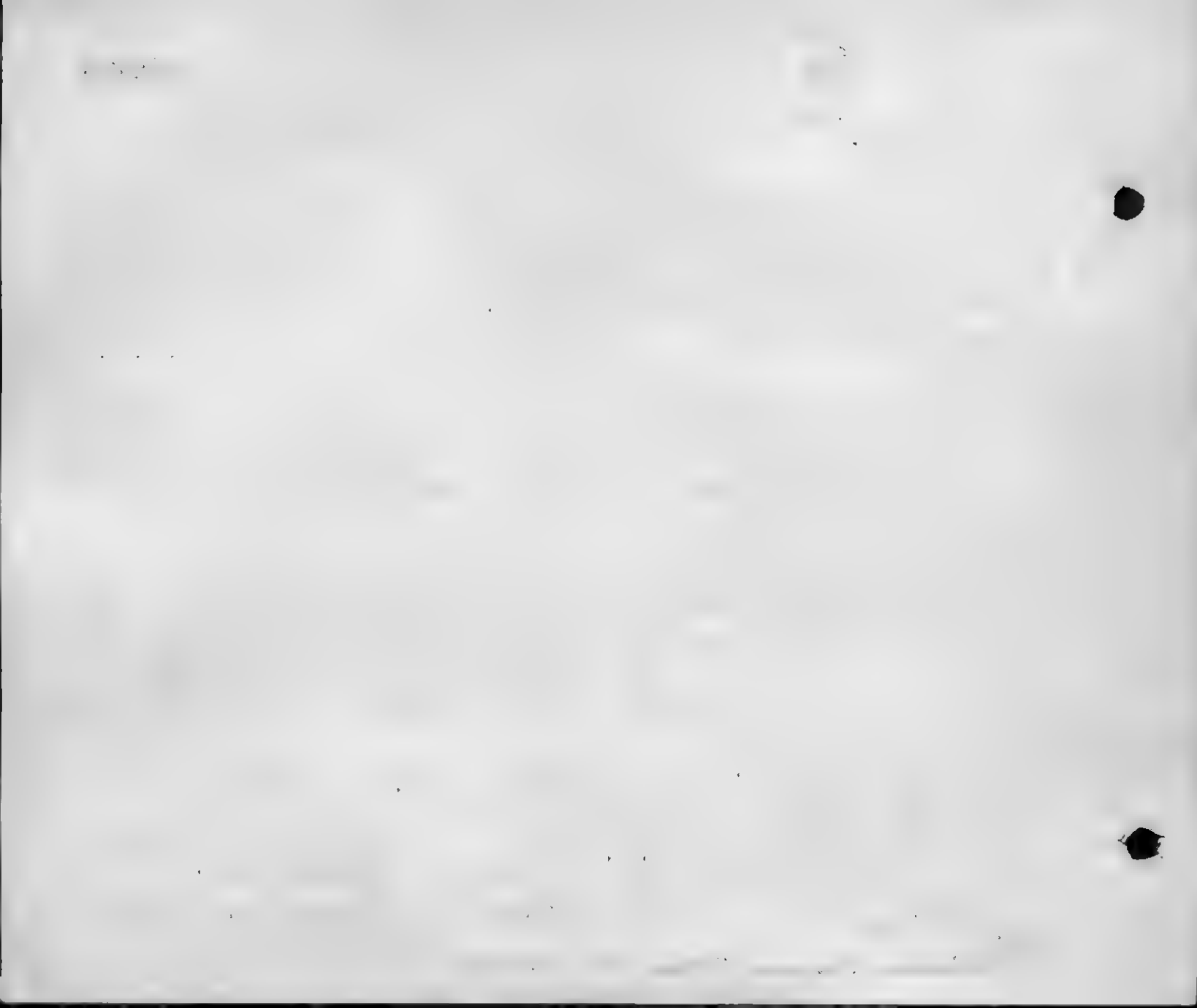
09964

1. PLACE OF DEATH a. COUNTY <div style="text-align: center; font-size: 1.2em;">Baltimore</div>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <div style="text-align: center; font-size: 1.2em;">Maryland</div>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Catonsville</div>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Baltimore</div>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">SPRING GROVE STATE HOSPITAL</div>		d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">702 West Fayette St.</div>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center; font-size: 1.2em;">Robert O'Rourke</div>		4. DATE OF DEATH <div style="text-align: center; font-size: 1.2em;">September 23 1961</div>	
5. SEX <div style="text-align: center; font-size: 1.2em;">male</div>		6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">white</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">Aug. 5, 1880</div>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">laborer</div>		9b. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <div style="text-align: center; font-size: 1.2em;">81 yrs. Months Days Hours Min.</div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">laborer</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 1.2em;">Maryland</div>	
11. BIRTHPLACE (Country & State, or foreign country) <div style="text-align: center; font-size: 1.2em;">Maryland</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">U. S. A.</div>	
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">Unknown</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">unknown</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <div style="text-align: center; font-size: 1.2em;">unknown</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.2em;">unknown</div>	
17. INFORMANT <div style="text-align: center; font-size: 1.2em;">Records: SPRING GROVE STATE HOSPITAL</div>		18. INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center; font-size: 1.2em;">Arteriosclerotic cardiovascular disease</div>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="text-align: center; font-size: 1.2em;">Arteriosclerotic cardiovascular disease</div>		19. WAS AUTOPSY PERFORMED? <div style="text-align: center; font-size: 1.2em;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="text-align: center; font-size: 1.2em;">Gene ralized arteriosclerosis</div>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a: <div style="text-align: center; font-size: 1.2em;">Arteriosclerotic cardiovascular disease</div>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <div style="text-align: center; font-size: 1.2em;">Arteriosclerotic cardiovascular disease</div>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center; font-size: 1.2em;">Arteriosclerotic cardiovascular disease</div>	
20c. TIME OF INJURY Month, Day, Year <div style="text-align: center; font-size: 1.2em;">19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div style="text-align: center; font-size: 1.2em;">SPRING GROVE STATE HOSPITAL</div>		20f. (City or town) (County) (State) <div style="text-align: center; font-size: 1.2em;">Catonsville 28, Md.</div>	
21. I certify that (If this hospital attended the deceased from May 29 1954 to Sept. 23 1961, that (I) (we) last saw the deceased alive on Sept. 23 1961, and that death occurred at 12:45 P.M. from the causes and on the date stated above)			
22a. SIGNATURE <div style="text-align: center; font-size: 1.2em;">Stella Wachslar, M. D.</div>		22b. DATE SIGNED <div style="text-align: center; font-size: 1.2em;">9-26-61</div>	
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">Stella Wachslar, M. D.</div>		22d. ADDRESS <div style="text-align: center; font-size: 1.2em;">SPRING GROVE STATE HOSPITAL</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial Sept 28-61 New Catholic</div>		23b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">Sept 28-61</div>	
23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">New Catholic</div>		23d. LOCATION (City, town or county) (State) <div style="text-align: center; font-size: 1.2em;">Old Frederick Road #29</div>	
24. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Funeral Home 1216 S. Charles St.</div>		25a. REC'D BY REGISTRAR <div style="text-align: center; font-size: 1.2em;">SEP 29 '61</div>	
25b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Arthur S. Kline</div>		25c. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Arthur S. Kline</div>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

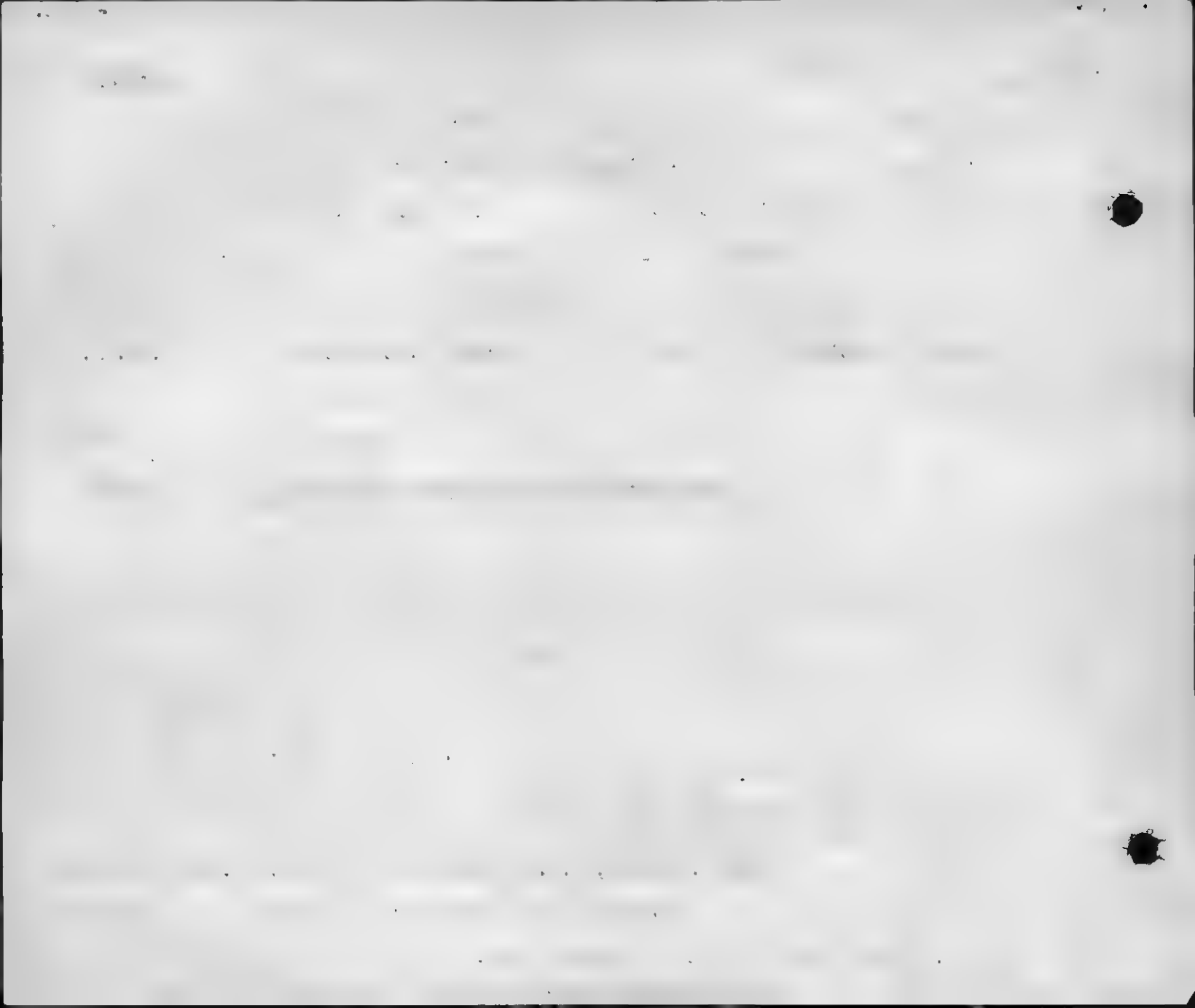
1 (M)

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9973 CERTIFICATE OF DEATH 99965									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY in 1b 41 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 1007 Sarah Ann Street i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) DAVID First Middle Last OWENS					4. DATE OF DEATH Month Day Year September 6 1961				
5. SEX Male					6. COLOR OR RACE Negro				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH May 6, 1899				
9. AGE (In years last birthday) 62					10. F UNDER 1 YEAR Months Days 62				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister - Retired					10b. KIND OF BUSINESS OR INDUSTRY Religion				
11. BIRTHPLACE (County & State, or foreign country) Marion, S. Carolina					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME George Owens					14. MOTHER'S MAIDEN NAME Hannah Garrison				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I					16. SOCIAL SECURITY NO. WW I				
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Address Fort Howard Division					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE RECTUM WITH METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 154 X INTERVAL BETWEEN ONSET AND DEATH 1 YEAR				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 27, 1961 , to Sept. 6, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 6, 1961 , and that death occurred at 1:30 PM from the causes and on the date stated above.									
22a. SIGNATURE Thomas F. Crahan					22b. DATE SIGNED 9/7/61				
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.					22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 9-11-61				
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery					23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson					25a. REC'D BY REGISTRAR SEP 14 '61				
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					25c. ADDRESS Baltimore 17, Md.				

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9974

CERTIFICATE OF DEATH

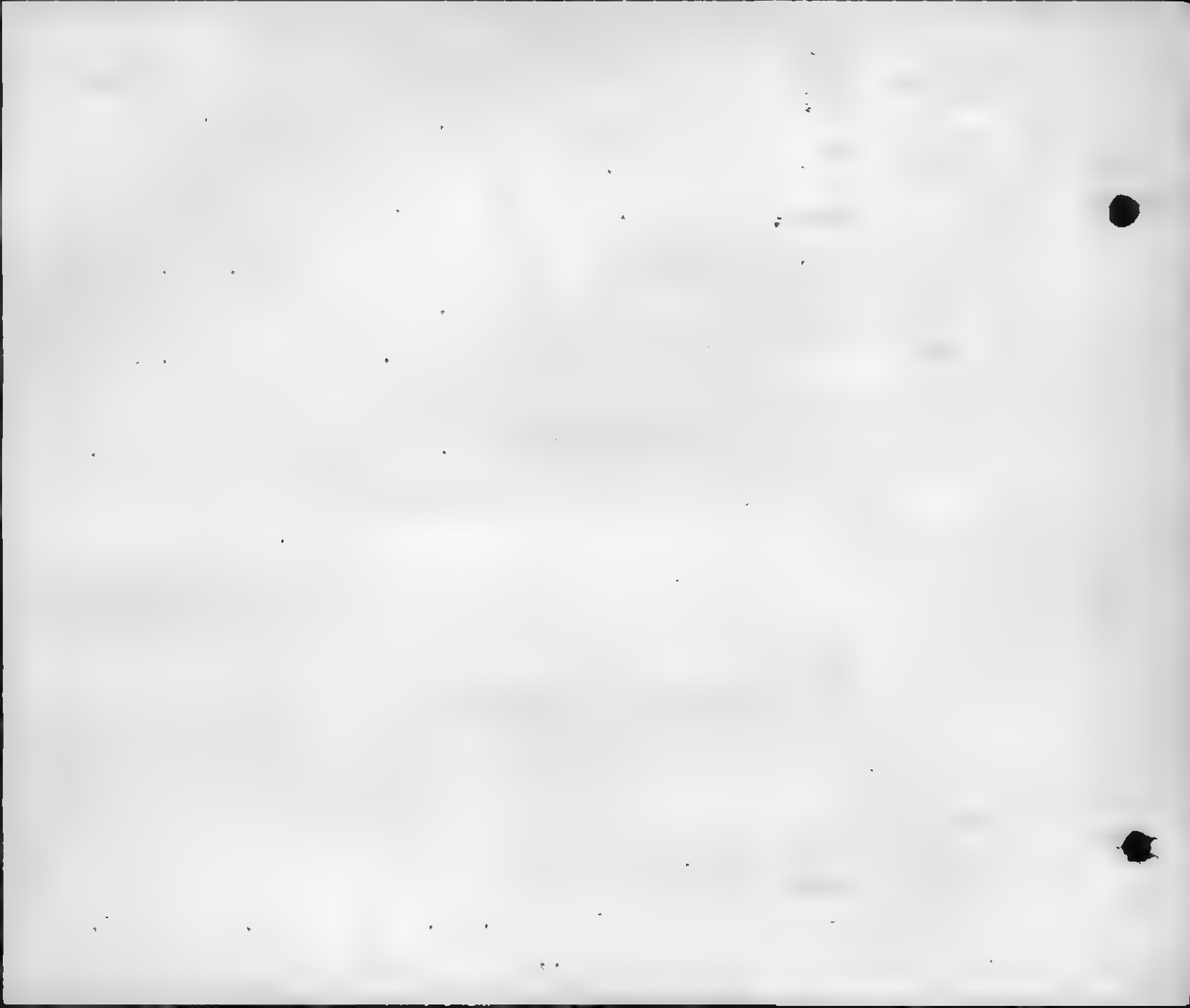
Reg. No. 9966

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 950 Fairmount Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucille Middle Myrtle Last Owens		4. DATE OF DEATH Month Sept. Day 1 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1909
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY High's Ice Cream W.Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Marteny		14. MOTHER'S MAIDEN NAME Daisy Kettle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 223-36-7368	
17. INFORMANT William H. Owens		Address 950 Fairmount Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacter Intestinal Hemorrhage DUE TO Cerebral Artery Dis P. Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old ulcer DUE TO (c) Old ulcer		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 61 , to 9/1 , 19 61 , that I last saw the deceased alive on 9/1 , 19 61 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
DEATH SIGNATURE Victor F. King M.D.		ADDRESS (Street, city or town, state) 1162 E. Joppa Rd. DATE SIGNED 9/1/61	
PHYSICIAN'S NAME (Type) Victor F. King.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-4-1961	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Prk.	22d. LOCATION (City, town, or county) (State) Howard Co., Md.
23. BURIAL DIRECTOR'S SIGNATURE G. Howard Strong		24a. REC'D BY REGISTRAR 5 '61	
ADDRESS 3207 W. North Ave.,		24b. REGISTRAR'S SIGNATURE Arthur L. King	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9975

Reg. Dist. No. 09967

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u> <u>Box 179</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Pearce</u> Last <u>Pearce</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/09</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lachinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACH. TOOL MFG.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Pearce</u>		14. MOTHER'S MAIDEN NAME <u>Prescilla Frankies</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>215-09-2855</u>	
17. INFORMANT <u>Records of Hospital</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Suicide</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Valley Rd. Catonsville</u> <u>by hanging himself by rope in chicken house on Shatz's place</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:45</u> <u>a. m.</u> <u>Sept 28</u> <u>19 61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Catonsville</u>	20f. (City or town) (County) (State) <u>Catonsville</u> <u>Balto</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo S. M. Kieffer</u>		DATE SIGNED <u>61</u>	
EXAMINER'S NAME (Type) <u>George S. M. Kieffer M.D.</u>		DEPUTY MEDICAL EXAMINER <u>1010 Leeds Ave. Sept. 28</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 21 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WAUGH CHAPEL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>GLEN ARM, BALTO. CO., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN BURNS' SONS, Towson, MD.</u>		24a. REC'D BY REGISTRAR <u>OCT 5 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>

MEDICAL CERTIFICATION

2

1020



1
 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

9976

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

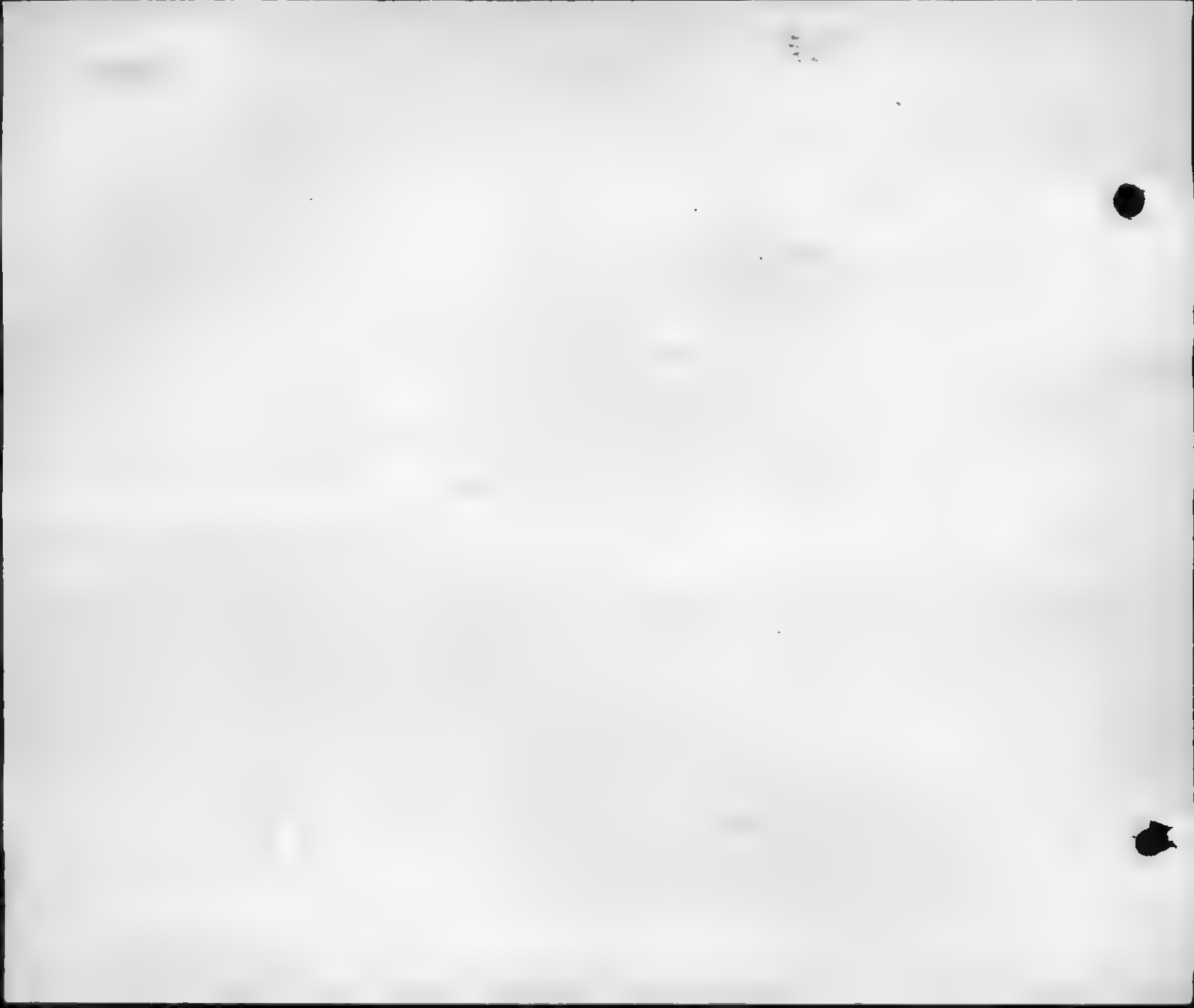
CERTIFICATE OF DEATH

09968

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATON VILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CATON RIDGE NURSING HOME		d. STREET ADDRESS 601 S MILTON AVE	
3. NAME OF DECEASED (Type or print) First NIKITA Middle PERKOWETZ Last PERKOWETZ		4. DATE OF DEATH Month SEPT Day 22 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 14 1885
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY BOX FACTORY	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? 1ST PAPERS	
13. FATHER'S NAME PAUL PERKOWETZ		14. MOTHER'S MAIDEN NAME UNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT IRENE PERKOWETZ		Address 1730 E 30TH ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized (c) Unknown			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Diabetes & Electrolyte Imbalance			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 15, 1961 , to Sept. 22, 1961 , that (I) (we) last saw the deceased alive on Sept. 19, 1961 , and that death occurred at 7:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE Cliff Ratliff, Jr.		22b. ADDRESS 4605 EDMONDSON AVE	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 25 61	
23c. NAME OF CEMETERY OR CREMATORY ST ANDREW CEM.		23d. LOCATION (City, town, or county) (State) GERMAN HILL RD MD	
24. FUNERAL DIRECTOR'S SIGNATURE Slippel Bros		25a. REC'D BY REGISTRAR SEP 25 '61	
ADDRESS 1800 E LOMBARD ST		25b. REGISTRAR'S SIGNATURE Arthur S. Frame	

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/6D

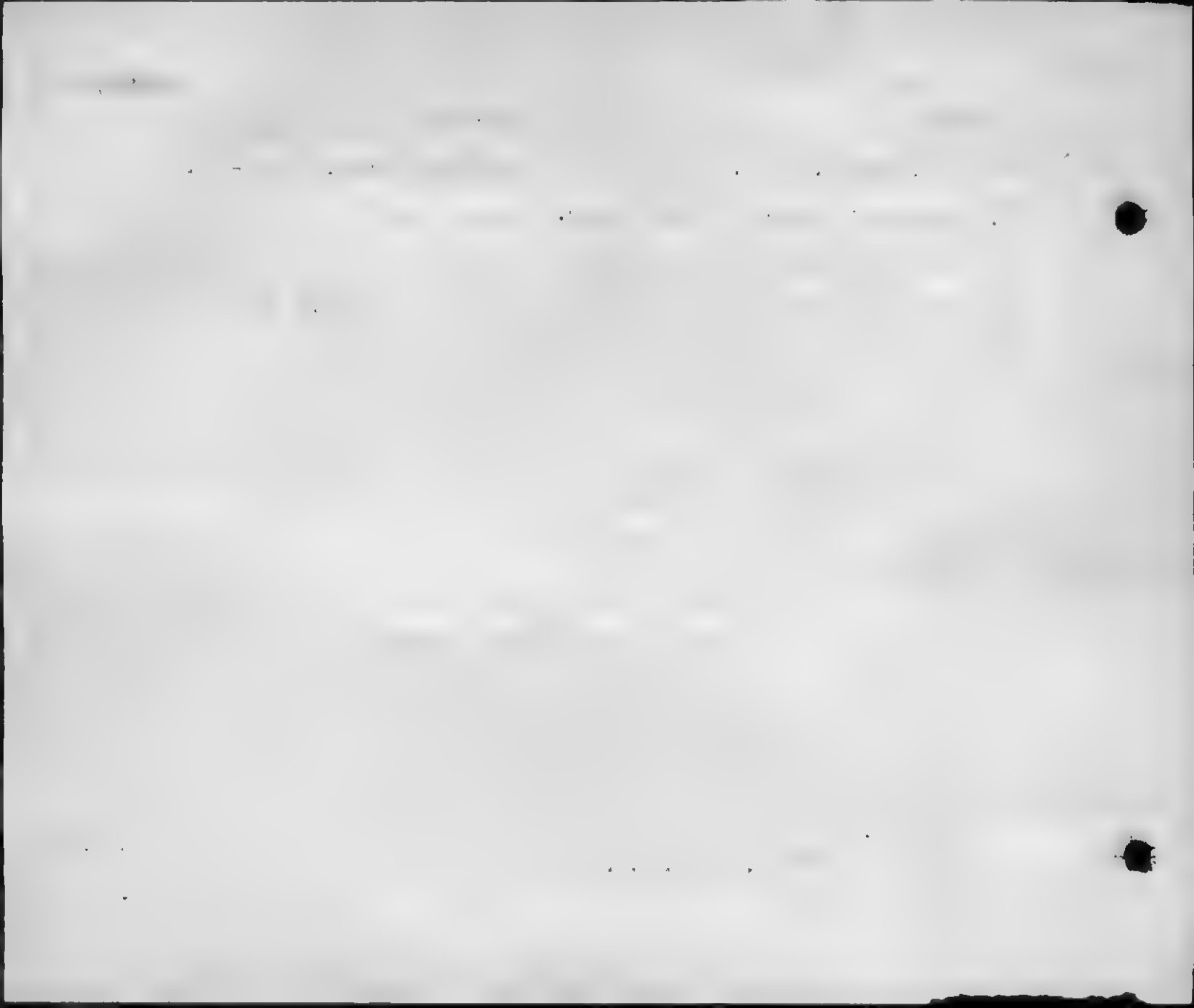
Item 18 Film 297 10-2-61
Item 18 Film 307 10-2-61
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09969

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1213 62nd Street, Balto - 6 c. LENGTH OF STAY IN 1b 1213 62nd Street, Balto - Rt. #7 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dr. Baumgardner's Office, Golden Ring Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution, give name and address) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1213 62nd Street, Balto - Rt. #7 d. STREET ADDRESS Same as above	
3. NAME OF DECEASED (Type or print) JIMMY EDWARD PEYTON		4. DATE OF DEATH Month 9 Day 25 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-5-1961	
9. AGE (In years, months, and days) 1 1/2 yrs.		10. IF UNDER 1 YEAR Months 18 Days 10 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME JOANNA PEYTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT JOANNA PEYTON		Address 1213 62nd St. Balto., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nutritional difficulty DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Thrombosis of left internal cerebral vein.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE Howard G. Shaub EXAMINER'S NAME (Type) H. OWARD G. SHAUB, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-27-61	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		22d. LOCATION (City, town, or country) (State) BALTO., MD.	
23. FUNERAL DIRECTOR Lissahn Sunil Home 7401 Belair Rd.		24a. REC'D BY REGISTRAR SEP 28 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

9-26-61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9978

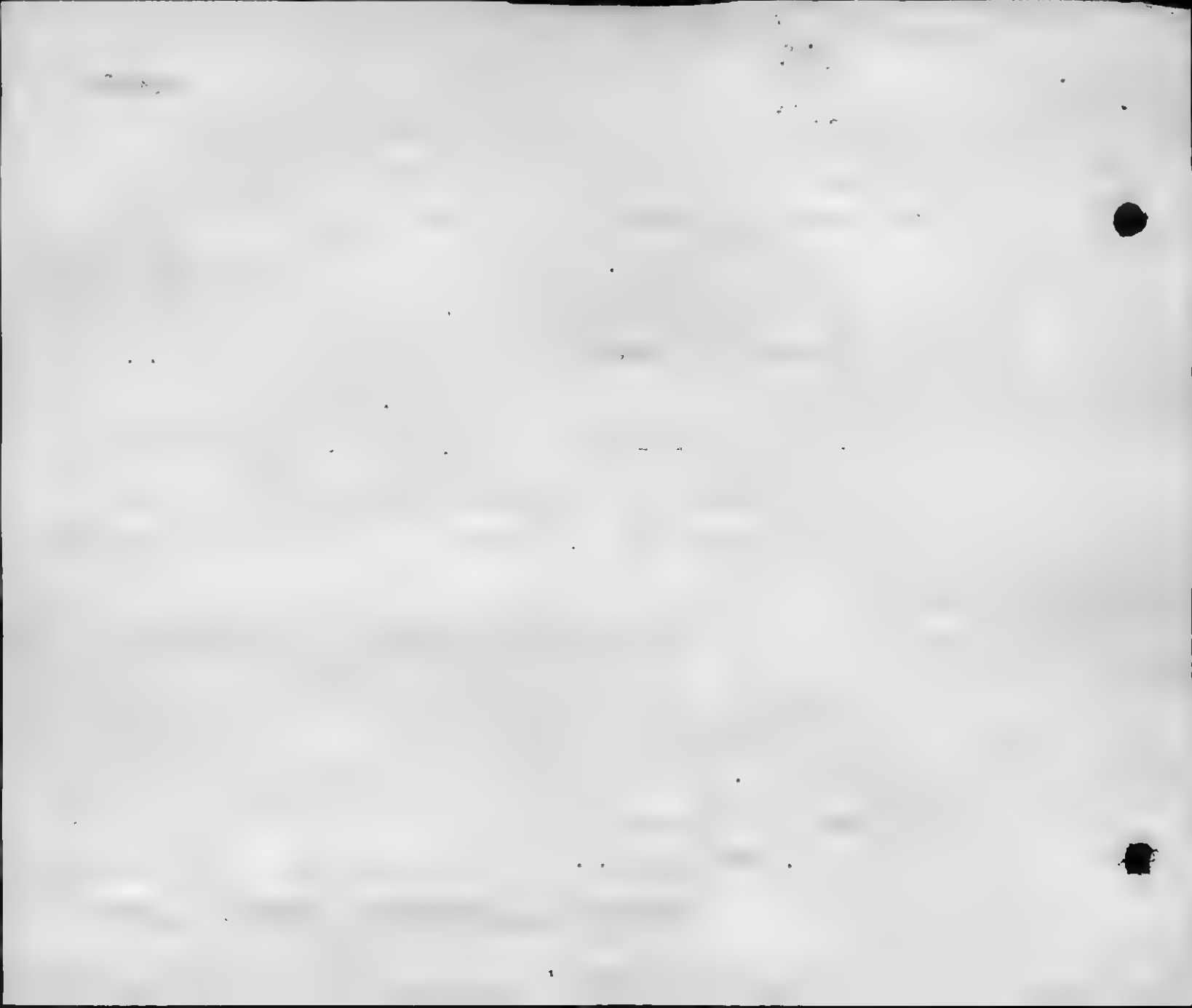
09970

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN (b) <u>34 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>8 Locust Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>WILLIAM W. PHIBBONS</u>			4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1961</u>			5. SEX <u>Male</u>										
6. COLOR OR RACE <u>White</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 30, 1918</u>										
9. AGE (in years, last birthday) <u>43</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Attendant</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Lothian, Maryland</u>		
IF UNDER 1 YEAR	IF UNDER 24 HRS.															
Months	Days															
	Hours															
	Min.															
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Early M. Phibbons</u>			14. MOTHER'S MAIDEN NAME <u>Ethel E. Wayson</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>217-16-8559</u>			17. INFORMANT <u>Baltimore, Maryland - FORT HOWARD DIVISION</u>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE DUE TO MITRAL STENOSIS</u> DUE TO (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>CEREBRAL EMBOLISM AND PULMONARY EMBOLI</u>								<u>UNKNOWN</u> <u>UNKNOWN</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>								
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)										
21. I certify that (IX) (this hospital) attended the deceased from August 5, 1961 to September 8, 1961 that (H) (we) last saw the deceased alive on Sept. 8, 1961, and that death occurred at A.M., from the causes and on the date stated above.																
22a. SIGNATURE <u>John D. Talbert</u>			22b. DATE SIGNED <u>9-9-61</u>			22c. PHYSICIAN'S NAME (Type) <u>JOHN D. TALBERT M.D.</u>										
22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>			22e. REC'D BY REGISTRAR			22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9-11-61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mount Zion Cemetery</u>										
23d. LOCATION (City, town or county) (State) <u>Anne Arundel County Maryland</u>			23e. ADDRESS <u>6009 Harford Road Baltimore 11, Md.</u>			23f. DATE <u>SEP 13 '61</u>										
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u>																

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

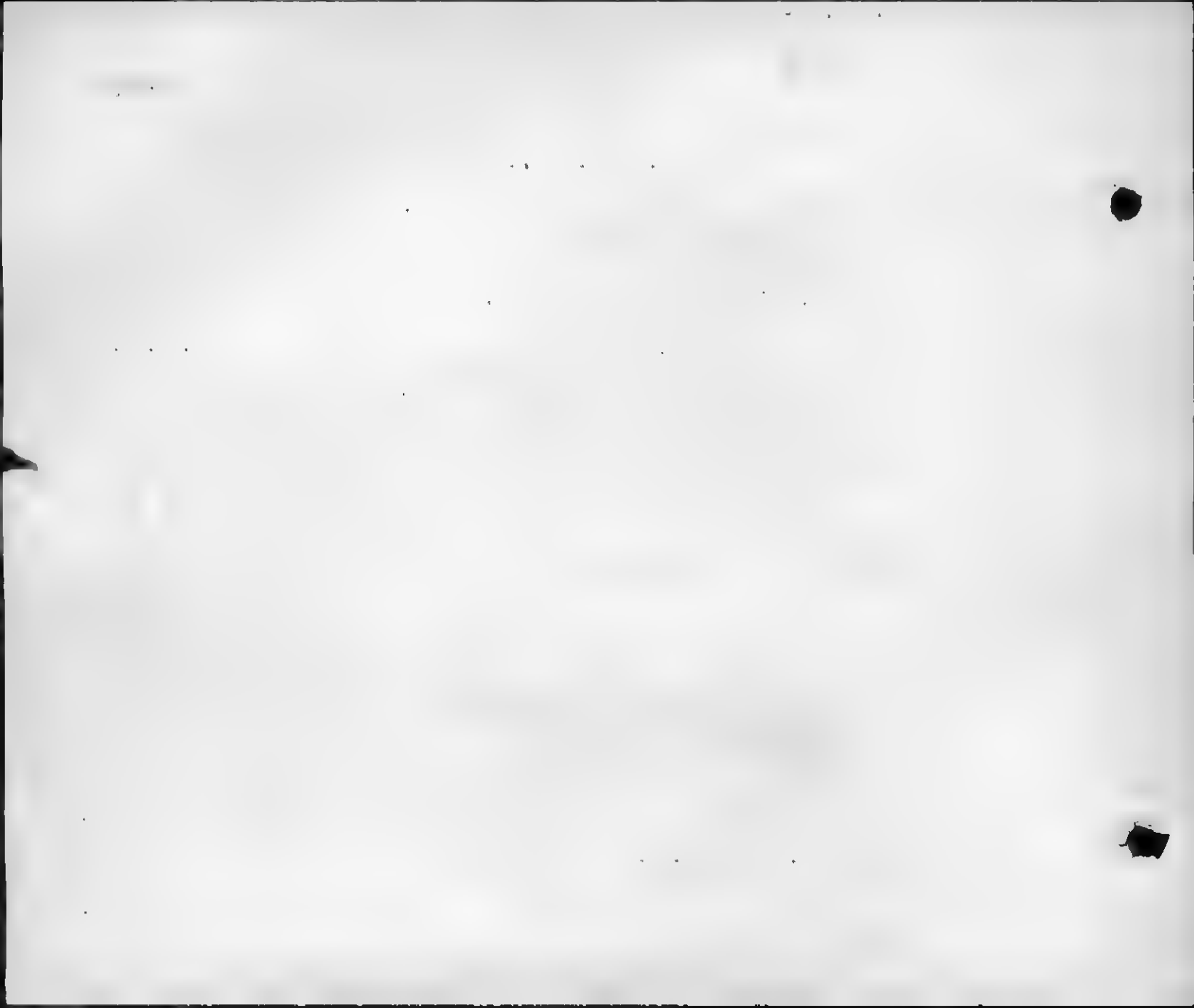
9979

09971

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence for care or institution) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN lb 4 Yrs. 16 Mos. 10 Ds.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE SHEPPARD AND ENOCH PRATT HOSPITAL				e. STREET ADDRESS 1107 St. Paul Street			
3. NAME OF DECEASED (Type or print) First John Middle William Last Pierson				4. DATE OF DEATH Month September Day 5 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1883	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Noah Robert Pierson				14. MOTHER'S MAIDEN NAME Mary McNabb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho pneumonia						Term	
DUE TO Pulmonary edema						5 da	
(b) Chronic myocarditis						5 hr +	
DUE TO Generalized Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome = C.A.S.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 25, 1956 to Sept 5, 1961 , that (I) (we) last saw the deceased alive on Sept 5, 1961 , and that death occurred at 2:45 PM , from the causes and on the date stated above							
22a. SIGNATURE W. W. Elgin		M. D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE September 5, 1961	
22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		22d. ADDRESS Towson 4, Maryland The Sheppard and Enoch Pratt Hospital,					
23a. BURIAL CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-8-61		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. W. Jenkins & Sons Co. 4905 York Rd. Balto				25a. REC'D BY REGISTRAR SEP 7 '61		25b. REGISTRAR'S SIGNATURE	

(M)

(1)



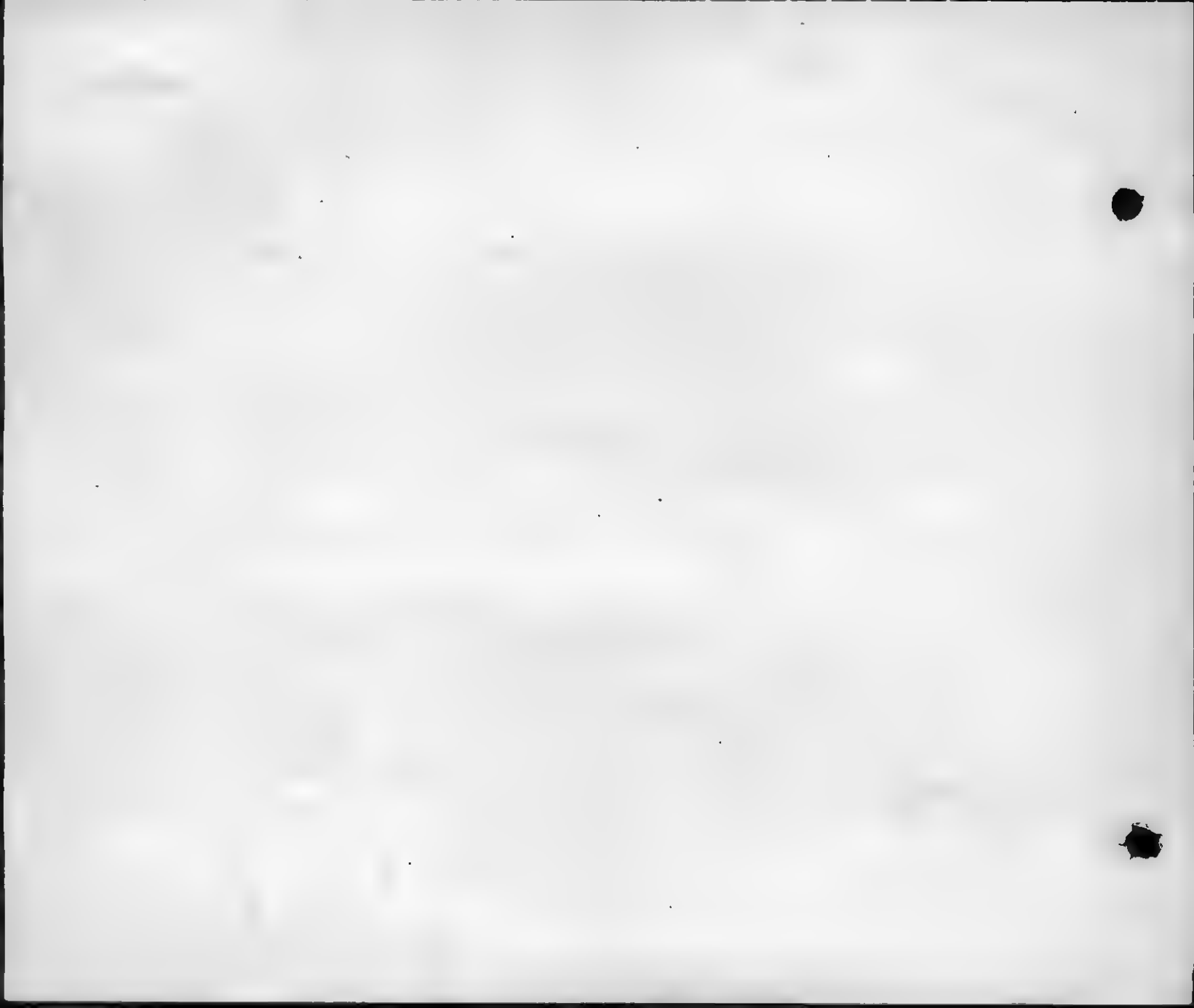
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, or the funeral director, may be relieved by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9980

09972

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside in institution) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>439 Rocky Point Road</i>				d. STREET ADDRESS <i>1439 Rocky Point Road.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Effie</i> Middle <i>E.</i> Last <i>Porter</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>29</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-10-1889</i>		9. AGE (In years last birthday) <i>71</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry Tutchton</i>				14. MOTHER'S MAIDEN NAME <i>Jane Stevenson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>212-42-6481</i>		17. INFORMANT <i>Charles Porter Box 439 Rocky Pt Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebro-Vascular apoplexy.</i> DUE TO <i>arteriosclerotic Cardio-Vascular disease 5 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> 19 <i>61</i> to <i>Sept 29</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Sept 30</i> 19 <i>61</i> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <i>M. Baumgardner</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10/2/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Baltimore Md.</i>				22d. ADDRESS <i>Baltimore Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-3-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Earl J. Hays</i>				25a. REC'D BY REGISTRAR <i>Oct 5 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hays</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

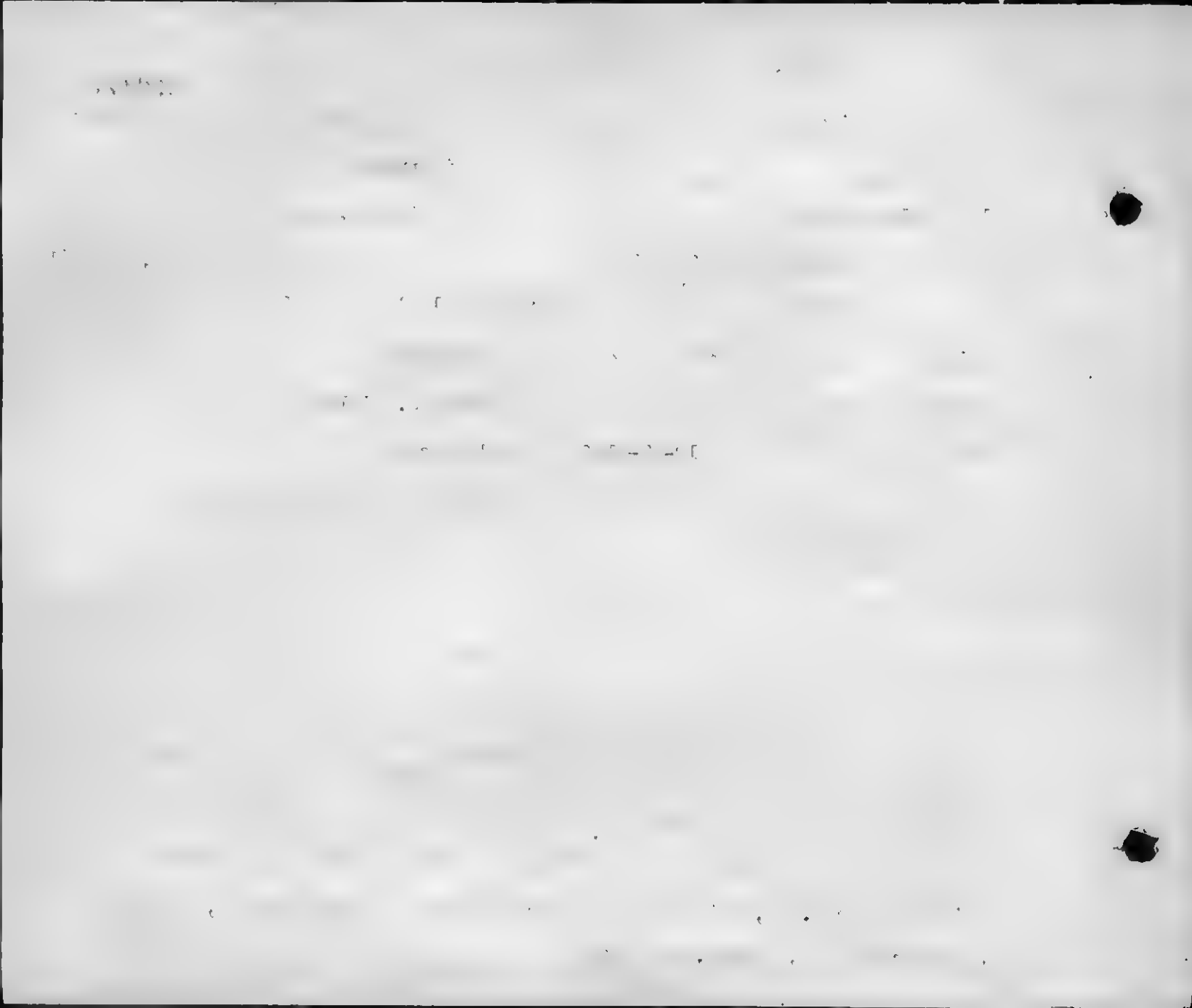
9981

CERTIFICATE OF DEATH

09973

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1711 Roland Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood d. STREET ADDRESS 1711 Roland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES JAMES PRICE First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH July 28, 1911 9. AGE (In years, last birthday) 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH September 22, 19 61 Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10b. KIND OF BUSINESS OR INDUSTRY Grocery Store 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Burton Price 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II 16. SOCIAL SECURITY NO. 219-07-9103 17. INFORMANT Family records		14. MOTHER'S MAIDEN NAME Amanda J. Miller 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of left lung 16 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4/27/1961 to 9/22/1961 , that (I) (we) last saw the deceased alive on 9/20/1961 , and that death occurred at 8 P.M. from the causes and on the date stated above. 22a. SIGNATURE M. K. Quinn M.D. 22b. DATE SIGNED 9/26/61 22c. PHYSICIAN'S NAME (Type) M. KEVIN QUINN 22d. ADDRESS 1927 YORK RD., TIMONIUH Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		23b. DATE THEREOF Sept. 26, 1961 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial 23d. LOCATION (City, town or county) Cockeysville, Maryland (State)					
25a. REC'D BY REGISTRAR SEP 28 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Howard							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

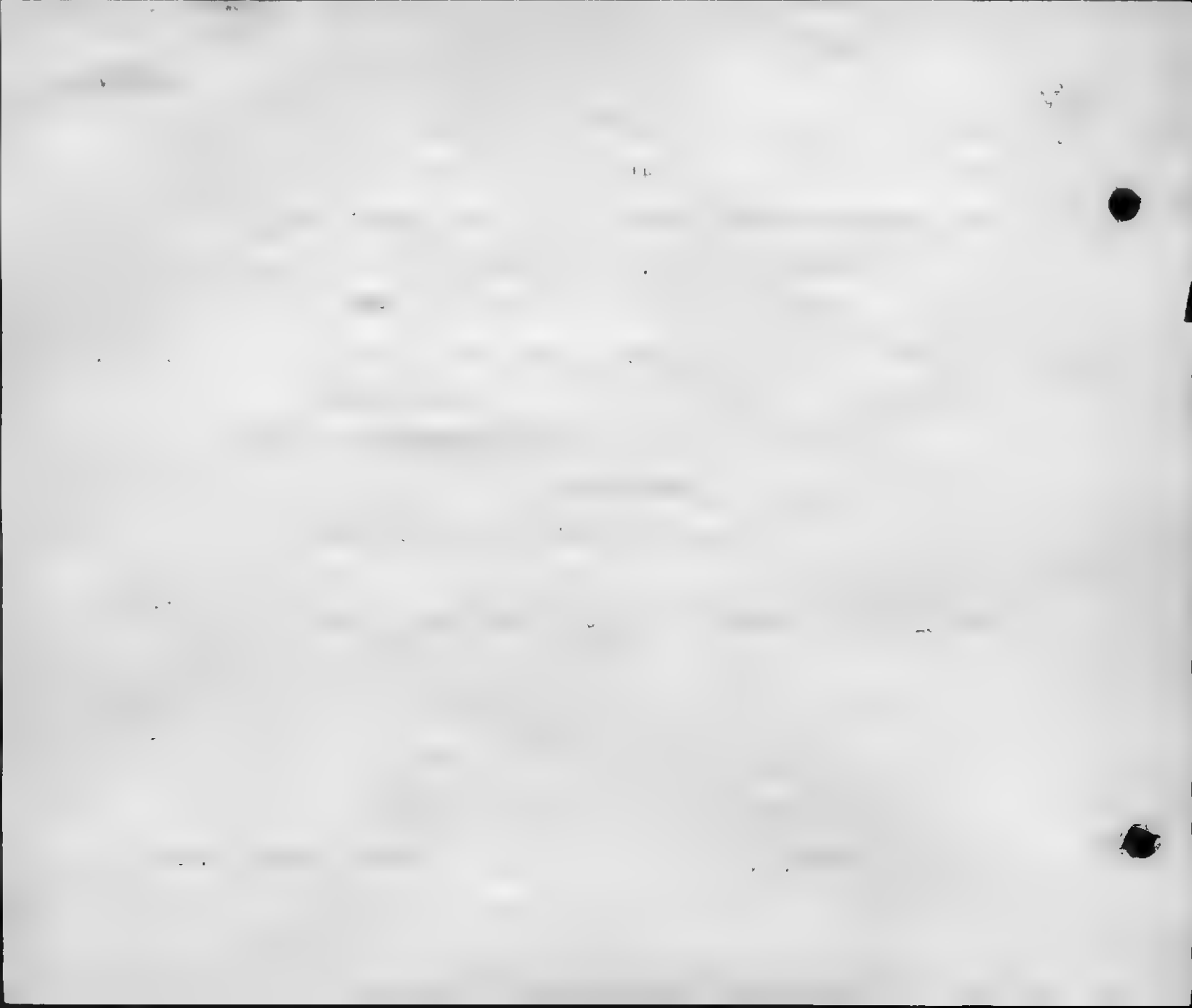


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9982 CERTIFICATE OF DEATH 09974											
Item 230, Film G-72 7/21/61 iwk											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30 d. STREET ADDRESS 2352 Annapolis Avenue							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN IN 41 Days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				f. DATE OF DEATH September 13 1961				g. AGE (In years last birthday) 42 yrs.			
3. NAME OF DECEASED (Type or print) MELVIN G. QUEEN				5. SEX Male				6. COLOR OR RACE Negro			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH August 25, 1919				9. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY County Sanitation				11. BIRTHPLACE (County & State, or foreign country) Severn, Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Rufus Queen				14. MOTHER'S MAIDEN NAME Columbine Oliver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 214-12-2099				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 415X Conditions, if any, which gave rise to immediate cause (b) CARCINOMA OF ESOPHAGUS, POST OPERATIVE (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)) Operation 8/31/61 Esophageal Gastrectomy-Carcinoma of esophagus				INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from August 3 1961 to September 13 1961 , that (2) (we) last saw the deceased alive on Sept. 13 1961 , and that death occurred at 6:15 A.M. from the causes and on the date stated above											
22a. SIGNATURE Thomas F. Crahan				22b. DATE 9/13/61				22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.			
22d. ADDRESS VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION				22e. REC'D BY REGISTRAR Arthur L. Kline				22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, 23b. DATE OF REMOVAL (Specify) Burial 9/15/61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore 28, Maryland				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home, 1631 Druid Hill Ave., Balto. Md.				25a. REC'D BY REGISTRAR SEP 19 61				25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9983

09975

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS 1730 E. Joppa Road

3. NAME OF DECEASED (Type or print)
Joseph Clarence Ray
First Middle Last

4. DATE OF DEATH
Sept. 25 1961
Month Day Year

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 2-11-1900
Last First Middle

9. AGE (in years, if under 1 year, last birthday) 61 yrs. Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber
11. BIRTH PLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Howard C. Ray
14. MOTHER'S MAIDEN NAME Mary Elizabeth Fuchs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 215-03-6176
17. INFORMANT Catherine Ray Address SAME

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
19X DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

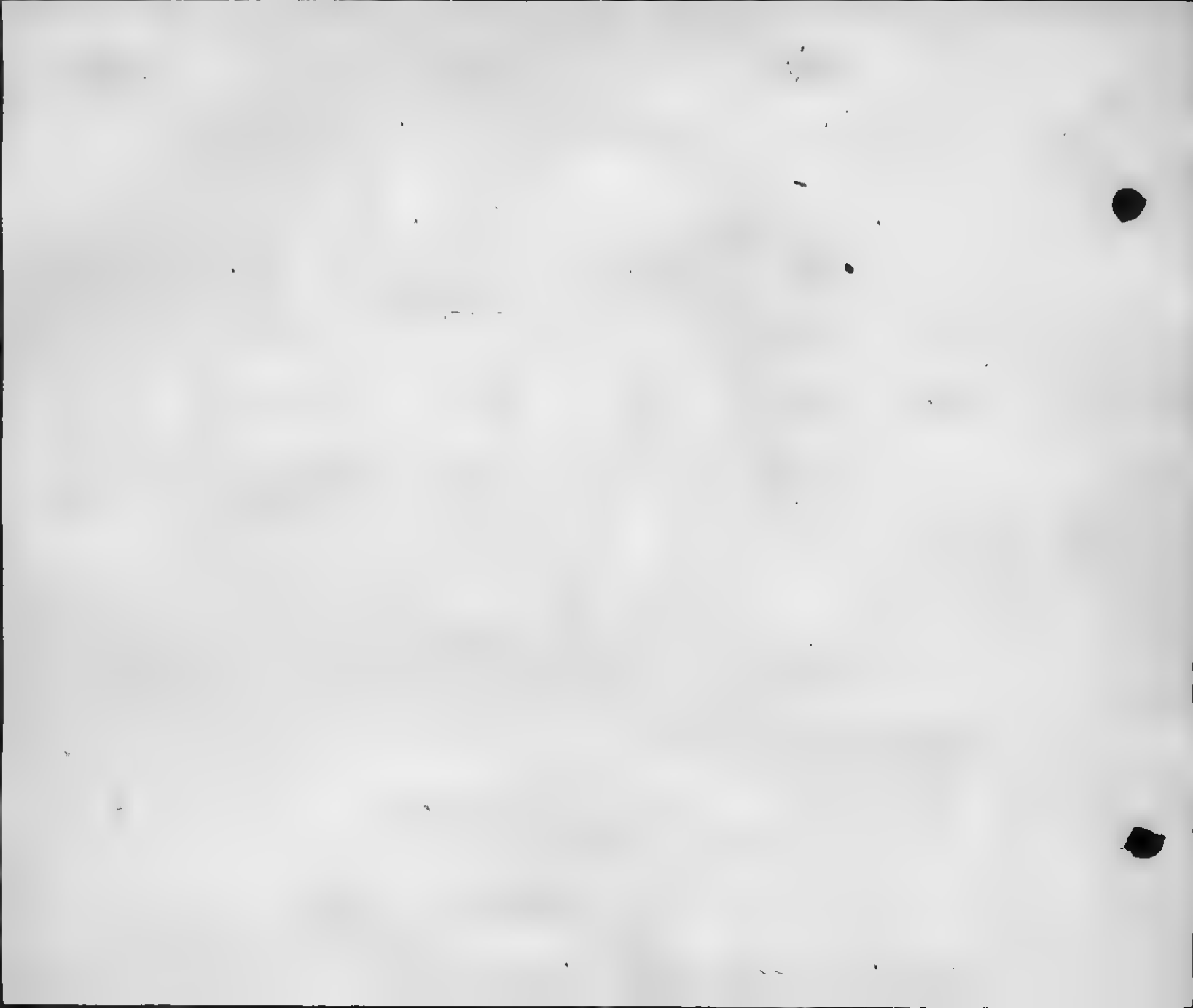
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (the attending physician) attended the deceased from Oct 1960 to Sept 25, 1961, that (I) last saw the deceased alive on 9-22-61 and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE Joseph F. Pira M.D. ATTENDING PHYS. MED. DIRECTOR ☒ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type) Joseph F. Pira 22d. ADDRESS 8400 Loch Raven Blvd. Balt 4, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 9/27/61 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer 23d. LOCATION (City, town or county) (State) BALTIMORE Md.

24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Rd. 25a. REC'D BY REGISTRAR SEP 26 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



FOR STATE
HEALTH DEPT

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9984 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13 & 14 fill G-297-10/9/61-1wk

09976

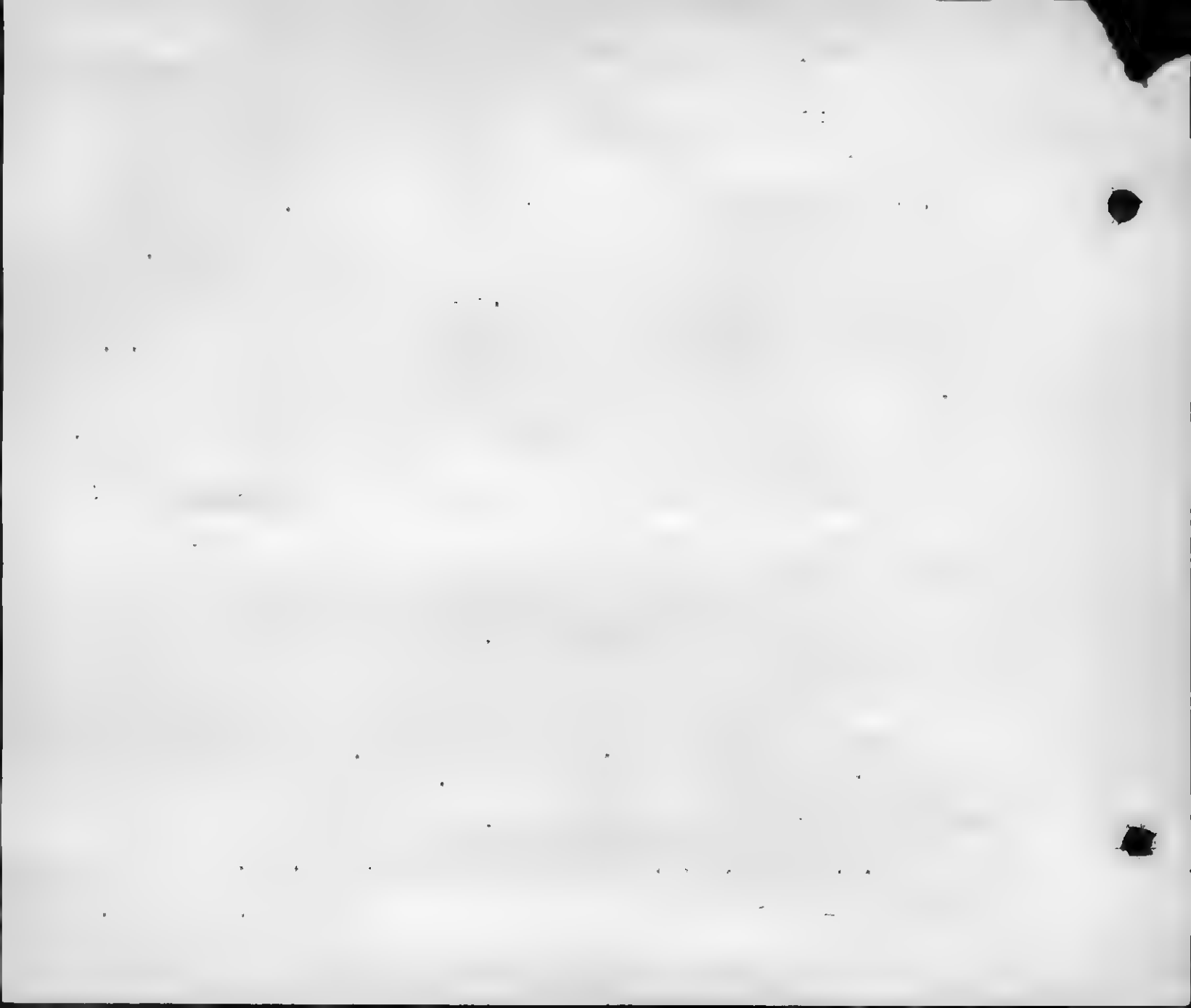
1. PLACE OF DEATH a. COUNTY <u>BALTO</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STONLEIGH</u>		c. LENGTH OF STAY IN 1b <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before adm ssion) a. STATE <u>MD</u>		b. COUNTY <u>1st</u>	
3. NAME OF DECEASED (Type or print) <u>CONRAD J. RETHSCHULTE</u>		4. DATE OF DEATH <u>Sept 25</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/12/1904</u>		9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>FREDERICK H. RETHSCHULTE</u>		14. MOTHER'S MAIDEN NAME <u>FREDERICKA SCHNEIDER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-8522</u>	
17. INFORMANT <u>WIFE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO <u>2 yr</u> (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		22. EXAMINER'S NAME (Type)		22a. BÜRIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9/28, 61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE Cem.</u>	
22d. LOCAT ON (City, town, or country) <u>BALTO Co</u>		23. FUNERAL DIRECTOR <u>P. J. Heermann</u>		23a. REC'D BY REGISTRAR <u>EP 28 '61</u>		23b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		23c. ADDRESS <u>6067 HARFORD RD</u>	

MEDICAL CERTIFICATION



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

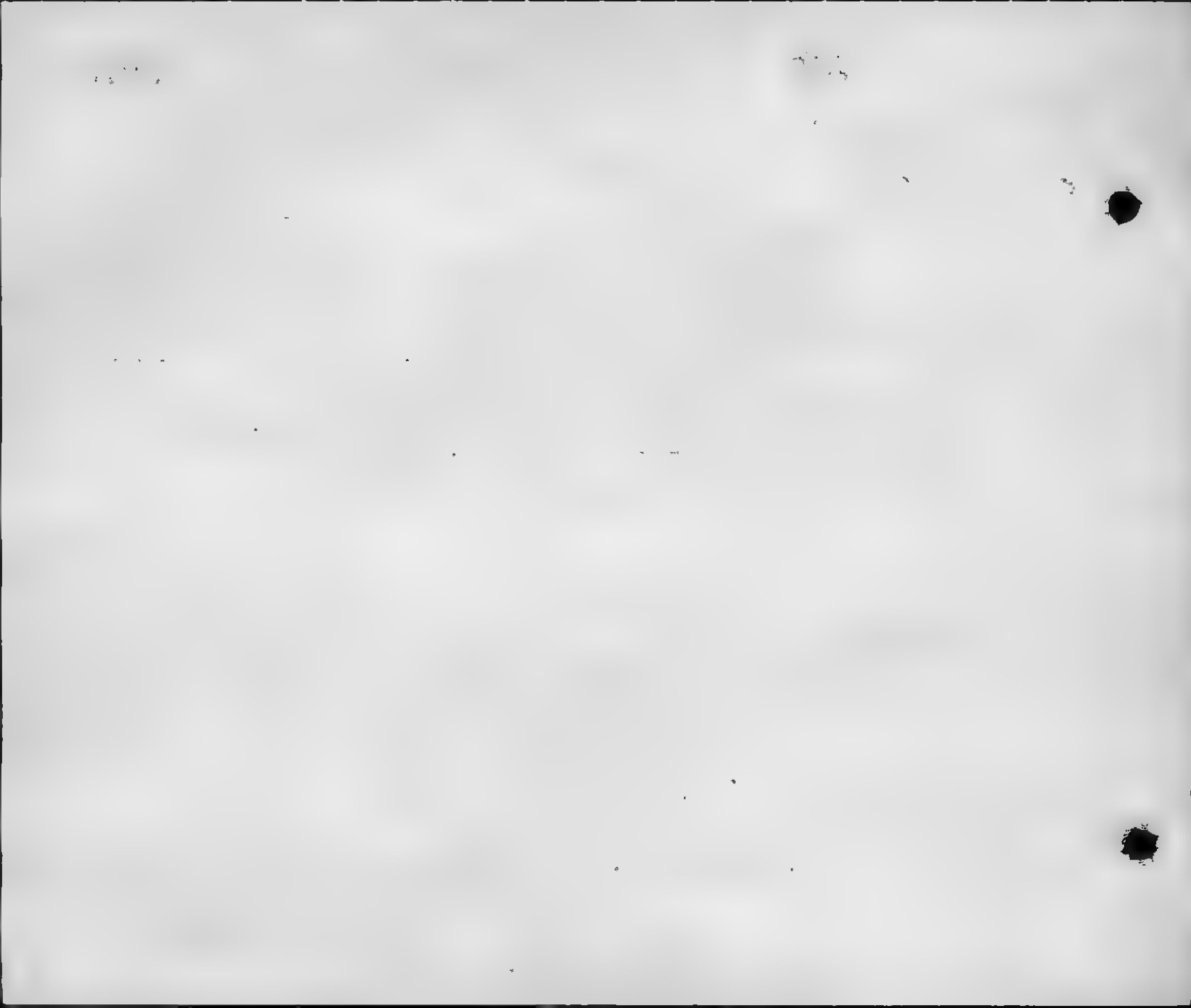
9985

CERTIFICATE OF DEATH

Item 220, RLM 6422 9/10/61 iwk

09978

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>46 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4004 Chesley Ave. - 6</u>	
3. NAME OF DECEASED (Type or print) <u>AUGUSTUS</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>November 25, 1871</u> 9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>September 8</u> 19 <u>61</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Runner</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Broker's Office</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick W. Richter</u> 14. MOTHER'S MAIDEN NAME <u>Louisa Busch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>SAW</u> 17. INFORMANT <u>Clinical Records, VA Hospital</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF PROSTATE</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Gastric Ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> UNKNOWN UNKNOWN 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 24</u> 19 <u>61</u> , to <u>Sept. 8</u> 19 <u>61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 8</u> 19 <u>61</u> , and that death occurred at <u>5</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>John D. Talbert</u> 22c. PHYSICIAN'S NAME (Type) <u>John D. Talbert, M.D.</u>		22b. DATE SIGNED <u>9-9-61</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/8/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Lasshan Funeral Home</u> 25a. REC'D BY REGISTRAR <u>SEP 14 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. Hamner</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 9979

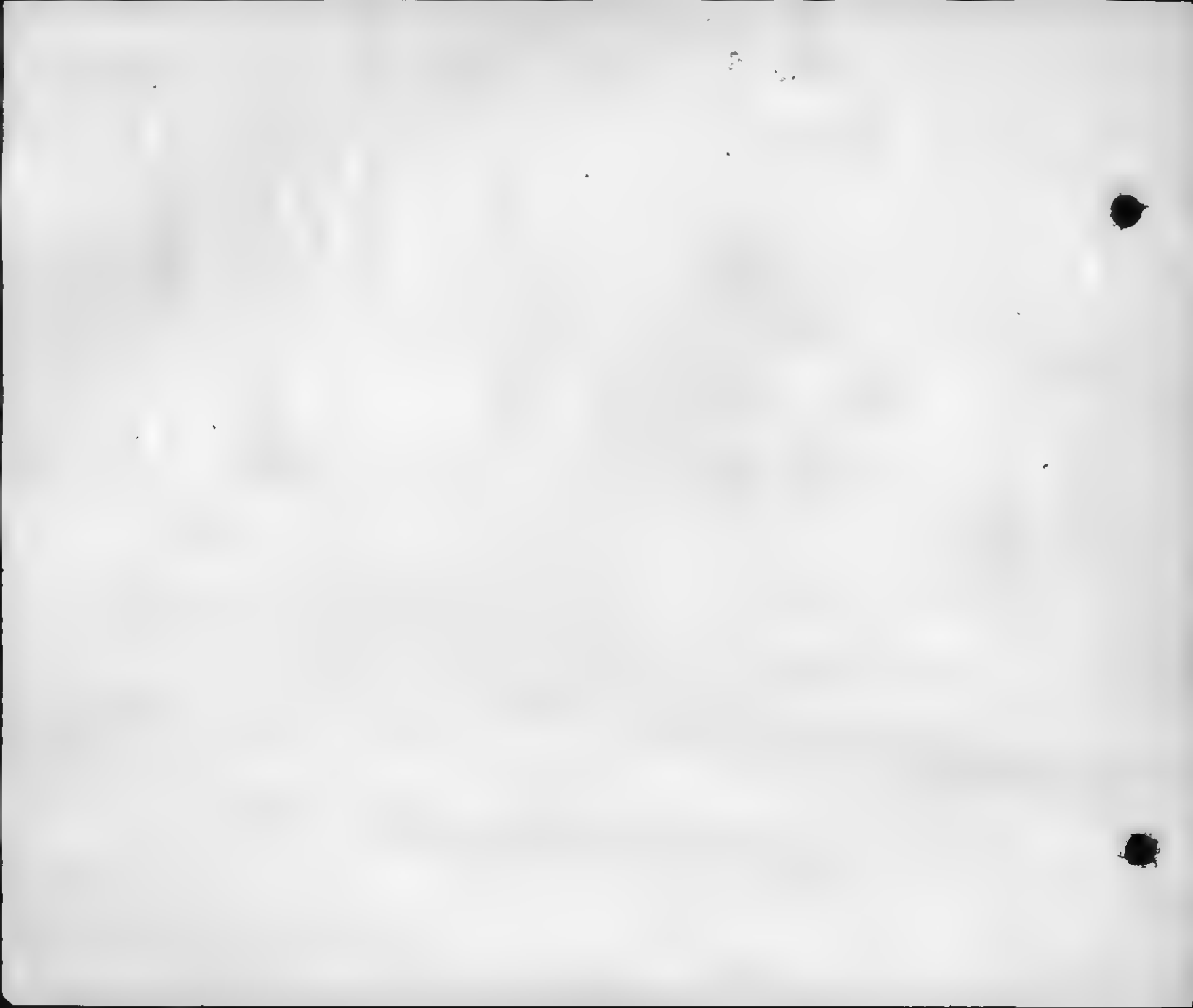
9987

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admitt on) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wash Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6711 Timberridge Rd, Baltimore Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Joshua</u> First <u>Oliver</u> Middle <u>Ritter</u> Last		4. DATE OF DEATH <u>Sept. 17</u> Month <u>17</u> Day <u>1961</u> Year		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 13 1871</u>		9 AGE (In years last birthday) yrs. <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farmhand</u>		11. BIRTHPLACE (State or foreign country) <u>Balti. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Charles Richard Ritter</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Ann Keller</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-10-03-587</u>		17. INFORMANT <u>Mrs. Sarah C. Ritter, 6711 Timberridge Rd.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, liver</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophy prostate</u> DUE TO (c) <u>Atherosclerosis, general</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 Jan</u> , 1956, to <u>9-12</u> , 1961, that I last saw the deceased alive on <u>9-12</u> , 1961, and that death occurred at <u>?</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles V. Williams</u> M.D. <u>1632 Reisters Town Road</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Charles A. Williams</u> <u>Pikesville 8, Md.</u>							
22a. BURIAL, CREMATION, REPOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Sept 19 1961</u>		<u>Laters Cemetery</u>		<u>Lutherville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				ADDRESS <u>Pikesville 8, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 2 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Released by Medical Examiner Dr. P. D. Copley
Funeral home of Dr. P. D. Copley



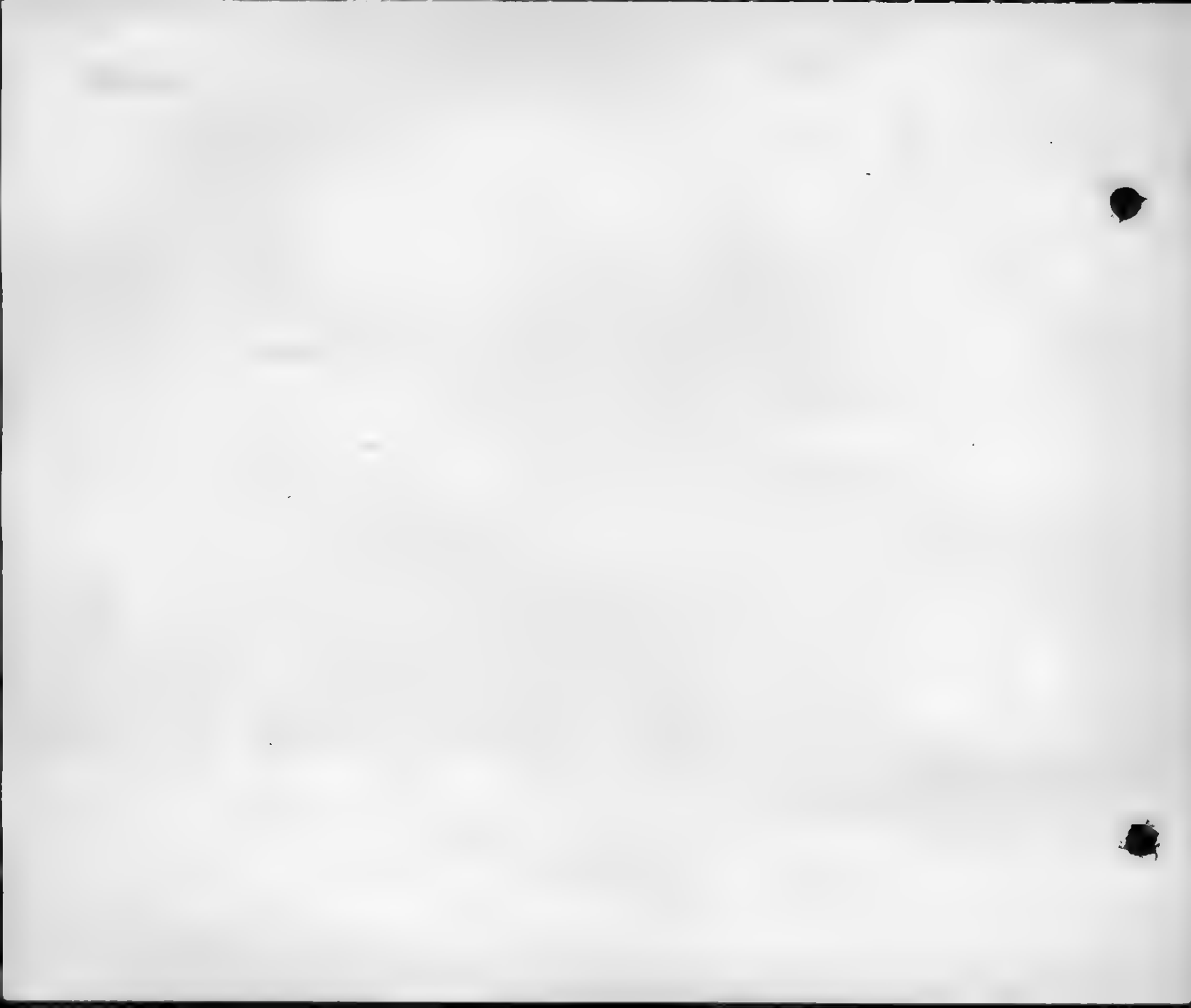
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9988

09980

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENWOOD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENWOOD			
c. LENGTH OF STAY IN 1b 36 YRS.				d. STREET ADDRESS 7410 KENLEA AVE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7410 KENLEA AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LENA Middle ROBIE Last ROBIE				4. DATE OF DEATH Month SEPT Day 16 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 14, 1890		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING			10b. KIND OF BUSINESS OR INDUSTRY SEWING		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ANDREW LEWIS				14. MOTHER'S MAIDEN NAME DOROTHY KOHLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO 213-09-26774		17. INFORMANT FREDERICK ROBIE 7410 KENLEA AVE #6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 5 yrs						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to 9/11/61 , that (I) (we) last saw the deceased alive on 9/11/61 , and that death occurred at 5:57 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. Bannardine M.D.				22b. DATE SIGNED 9/18/61		22c. PHYSICIAN'S NAME (Type) Balto 6 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/19/1961		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road #6 MD				25a. REC'D BY REGISTRAR DATE SEP 1 - '61		25b. REGISTRAR'S SIGNATURE Chet L. Thum	

TO HOSPITAL: ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

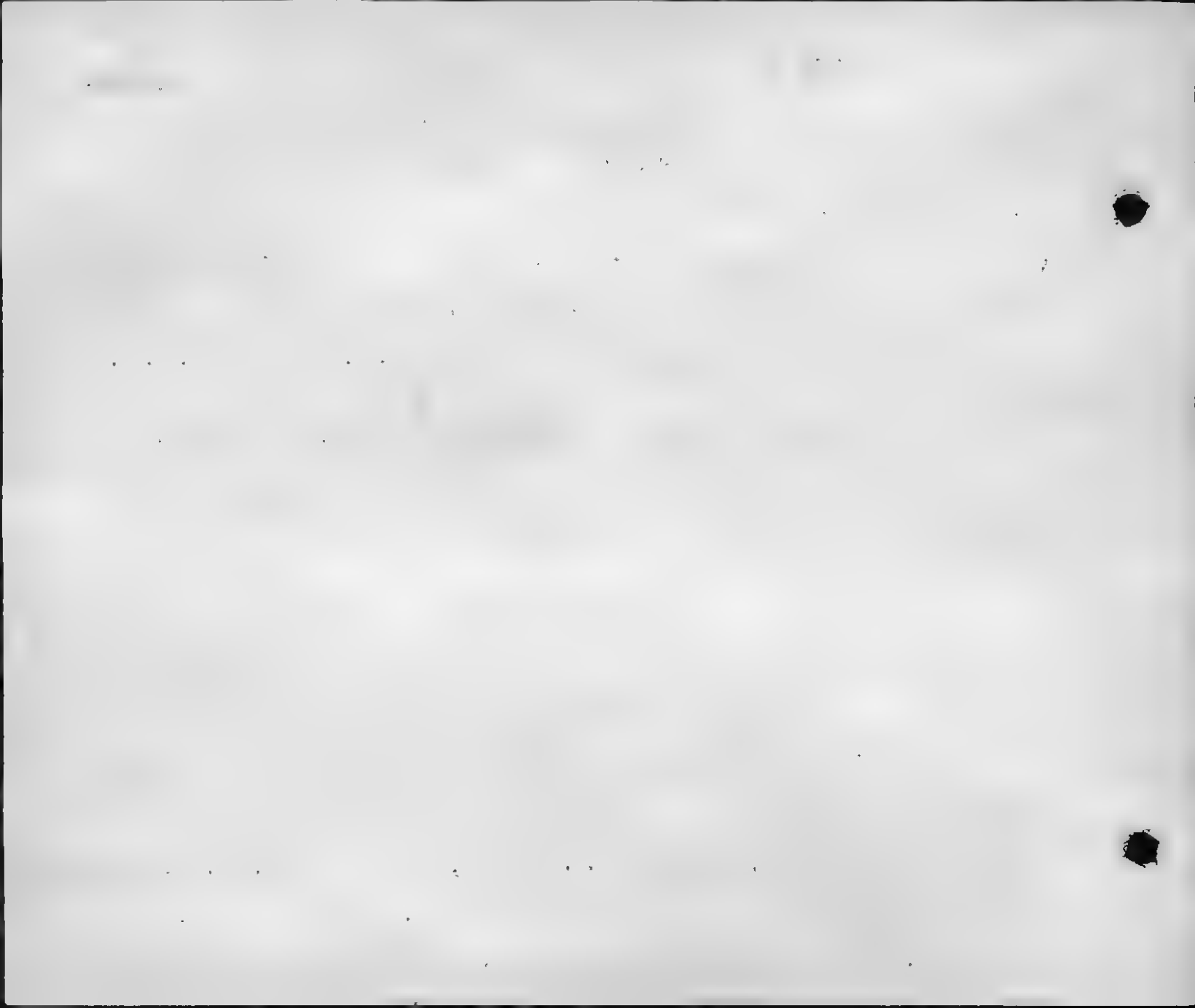


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death is not reported to the health department, the death certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9989
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 24 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1110 Druid Hill Avenue b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICK Middle --- Last ROBINSON		4. DATE OF DEATH Month September Day 21 Year 1961	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 17, 1897	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 17 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (County & State, or foreign country) Darlington, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jeff Robinson		14. MOTHER'S MAIDEN NAME Serena Charles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-14-2436	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		17. ADDRESS Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 3-1X DUE TO (b) Arteriosclerosis DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 3-4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) None			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None (County) None (State) None	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 28, 1961 to September 21, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 21, 1961 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22b. DATE 9/22/61 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town or county) Baltimore 28, Maryland (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Avenue, Balto. 17, Md.		25a. REC'D BY REGISTRAR SEP 27 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dis. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 20</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balta Co, ind. (Middle River)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Harrison St.</u>		d. STREET ADDRESS <u>Rt 16, Box 11, Balt 20.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Rosier</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lewis Rosier</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Riley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>717-078978</u>	
17. INFORMANT <u>Clarence L Rosier, Rt. 16, Box 11, Balt 20 Md</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart dis</u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>8/5</u> , 19 <u>61</u> , to <u>9/4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>61</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Edward Paul Berger, M.D.</u>			
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-8-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stablersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Barlenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>SEP 11 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **09983**

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>	
c. LENGTH OF STAY in 1b <u>136 yrs</u>		d. STREET ADDRESS <u>Liberty Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randallstown</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN KLAHR RUFF</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>0</u> M.n. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Ruff</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Klahr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-7235</u>	
17. INFORMANT <u>Mrs. Ruff - Randallstown, Md.</u>		Address <u>Randallstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning (Suicide)</u> 995X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Expressive</u> (c) <u>Expressive</u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intoxication</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u> <u>3 yrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Accident - found in front of pool</u>	
20c. TIME OF INJURY Month, Day, Year <u>Sept 15, 61</u> Hour a.m. <u>10</u> p.m. <u>00</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>Private Pool</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Private Pool</u>		20f. (City or town) (County) (State) <u>Randallstown Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>9/18/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or country) (State) <u>Randallstown, Maryland</u>	
23. FUNERAL DIRECTOR <u>Living Byers</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE SIGNED <u>Sept 15 '61</u>	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence if not Institution) e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>North Baltimore</u>		c. LENGTH OF STAY IN MD. <u>25 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3332 Eppitt Rd.</u>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Baltimore, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGUARITE T. RUND</u>		g. STREET ADDRESS <u>13332 Eppitt Rd.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-19, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Schultze</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schultze</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Mary J. Rund</u> Address <u>3332 Eppitt Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>none</u> DUE TO (c) <u>none</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3332 Eppitt Rd.</u>	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-16-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial</u>		22d. LOCATION (City, town, or country) (State) <u>Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Spring Byers</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '61</u>	
ADDRESS <u>8728 Liberty Rd. Randallstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

09984

INTERVAL BETWEEN ONSET AND DEATH
14 hrs.

DATE SIGNED

9-14-61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9993

CERTIFICATE OF DEATH

09985

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>6yrlmth9dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions residence, include admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>3308 Sumter Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Esther</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Last <u>Sachs</u> Month <u>September</u> Day <u>29</u> Year <u>1961</u> 8. DATE OF BIRTH <u>June 17, 1900</u> 9. AGE (in years) <u>60</u> IF UNDER 1 YEAR: Months <u>11</u> Days <u>12</u> IF UNDER 24 HRS.: Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> 11. BIRTHPLACE (Country or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Louis Sachs</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Cablinski</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown no</u> 16. SOCIAL SECURITY NO. <u>unknown no</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> (b) <u>Renal failure</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>593X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that <u>30</u> (this hospital) attended the deceased from <u>Aug. 17, 1955</u> , to <u>Sept. 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 29, 1961</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>H.H. Cholmondeley</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>H.H. Cholmondeley</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct 1/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Beth Jacob (Vecair)</u> 23d. LOCATION (City, town or county) <u>Rosedale, Maryland</u> (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>SOL LEVINSON & SONS, INC. - 6010 REISTERSTOWN RD.</u> 25a. REC'D BY REGISTRAR <u>OCT 4 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hantz</u>	

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

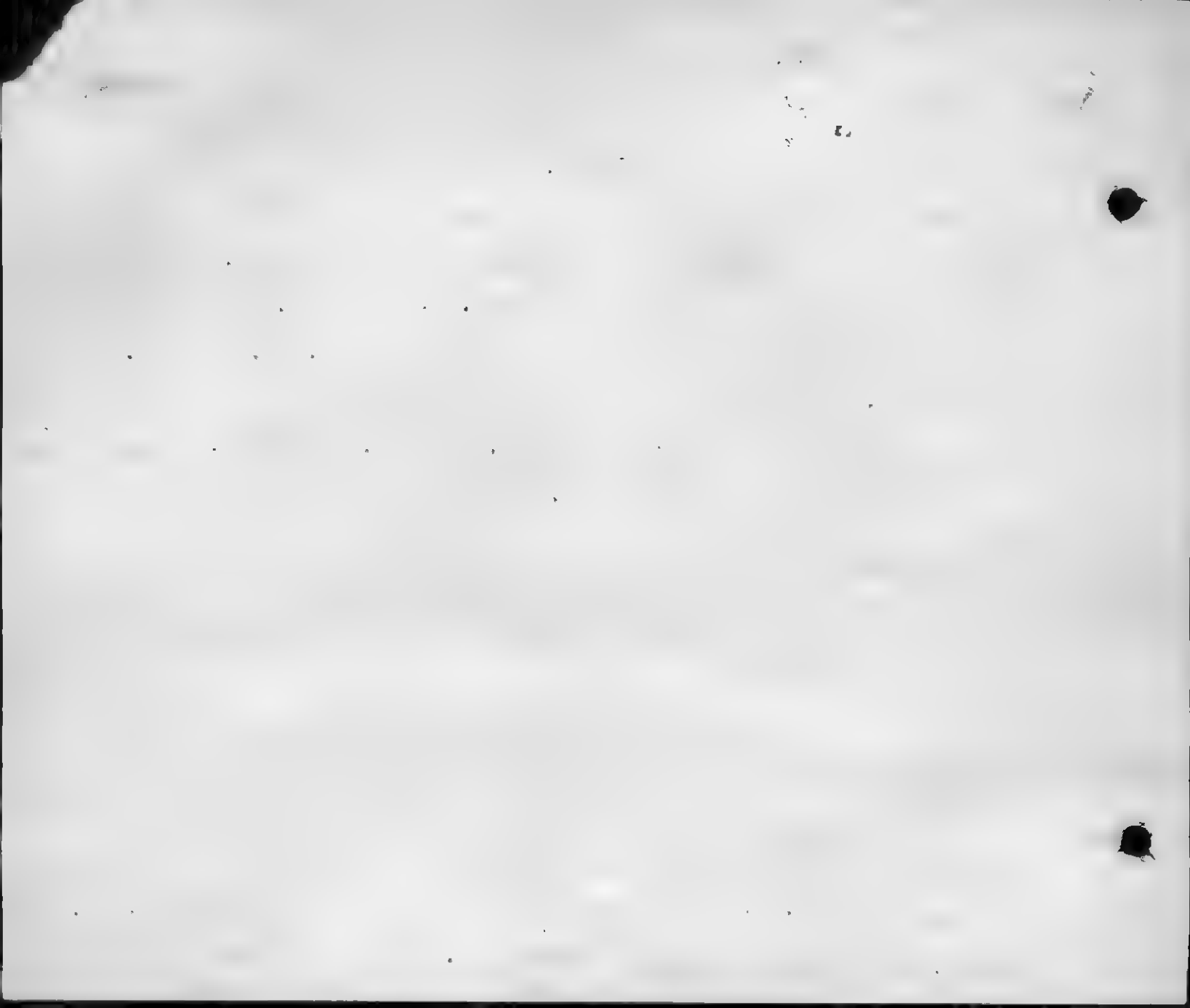
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

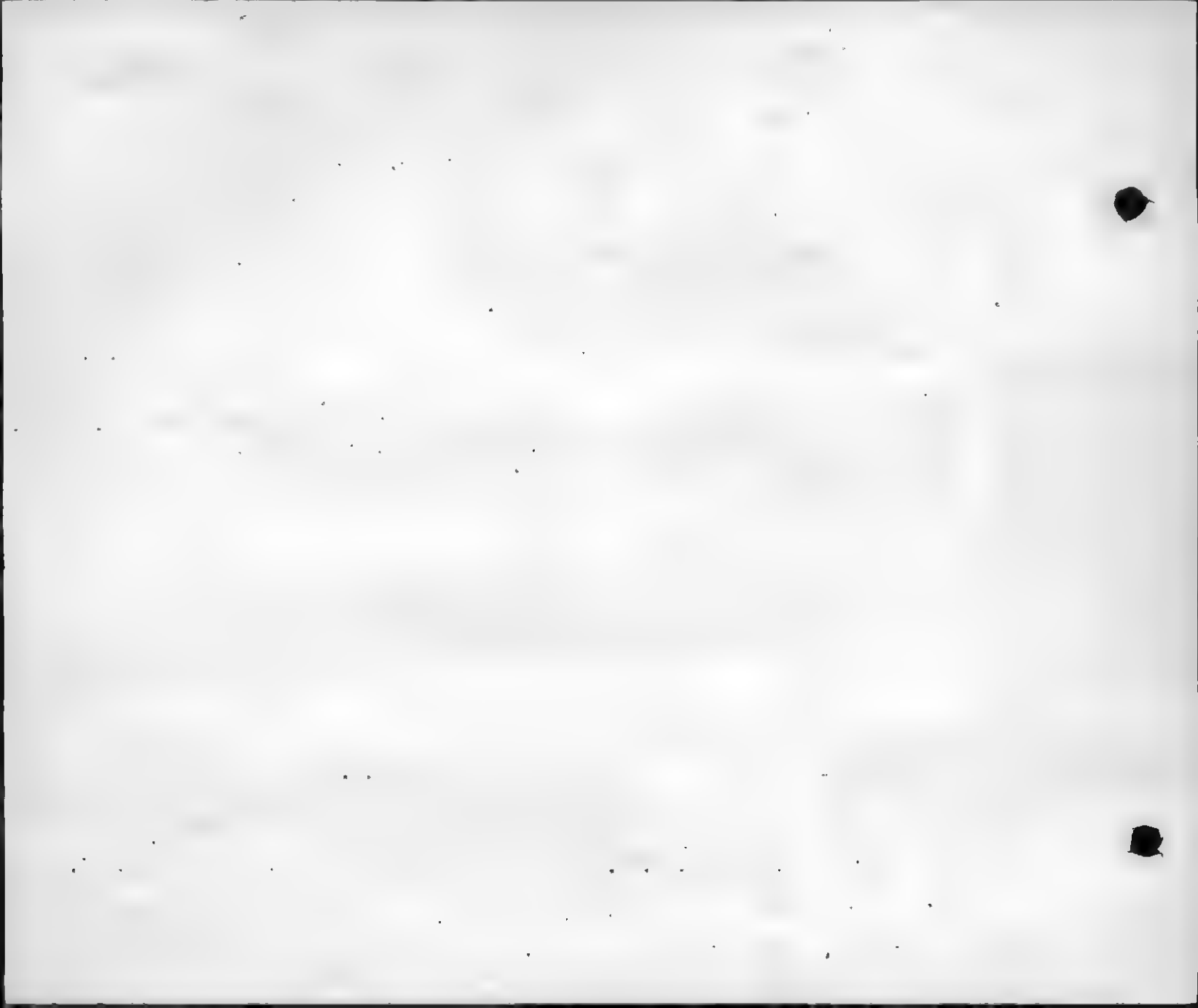
CERTIFICATE OF DEATH

9994

09987

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN It <u>47 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions, give name and address) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. STREET ADDRESS <u>Black Forest Road</u>			
3. NAME OF DECEASED (Type or print) <u>Darows</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16,</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George H. Schaeffer</u>			
14. MOTHER'S MAIDEN NAME <u>Edith Mae Poe</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-01-5440</u>			
17. INFORMANT <u>Mrs. Irene M. Schaeffer, Owings Mills, Md.</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.) <u> </u>					
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 16, 1961</u> , to <u>Sept 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 16, 1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Martin J. Feldman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/17/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Martin J. Feldman</u>		22d. ADDRESS <u>#1 Cherry Hill Rd Peristerstown Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Sept. 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore County, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry James Echhardt</u>		ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9996

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 0294 9/11/61 mh

Reg. Dist. No. 09989

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>552 Oakland Road</u>		d. STREET ADDRESS <u>5559 Oakland Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna M. Shepp</u>		4. DATE OF DEATH Month Day Year <u>Sept. 7, 1961</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1918</u>
9. AGE (in years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James J. Collins</u>	
14. MOTHER'S MAIDEN NAME <u>Antionette R. Koch</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-02-5111</u>		17. INFORMANT <u>Arthur S. Hubbard</u> Address <u>1010 Locust Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by Looping of cord</u> <u>974X</u> DUE TO <u>Bag tied over mouth and nose of cord</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>(Suicide)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been in bad health</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pinned placenta over her face and nose</u>	
20c. TIME OF INJURY Month, Day, Year <u>Sept. 1, 1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Baltimore</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. W. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. W. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard, 4107 Wilkens Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 6 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hubbard</u>		DATE SIGNED <u>SEP. 1, 1961</u>	

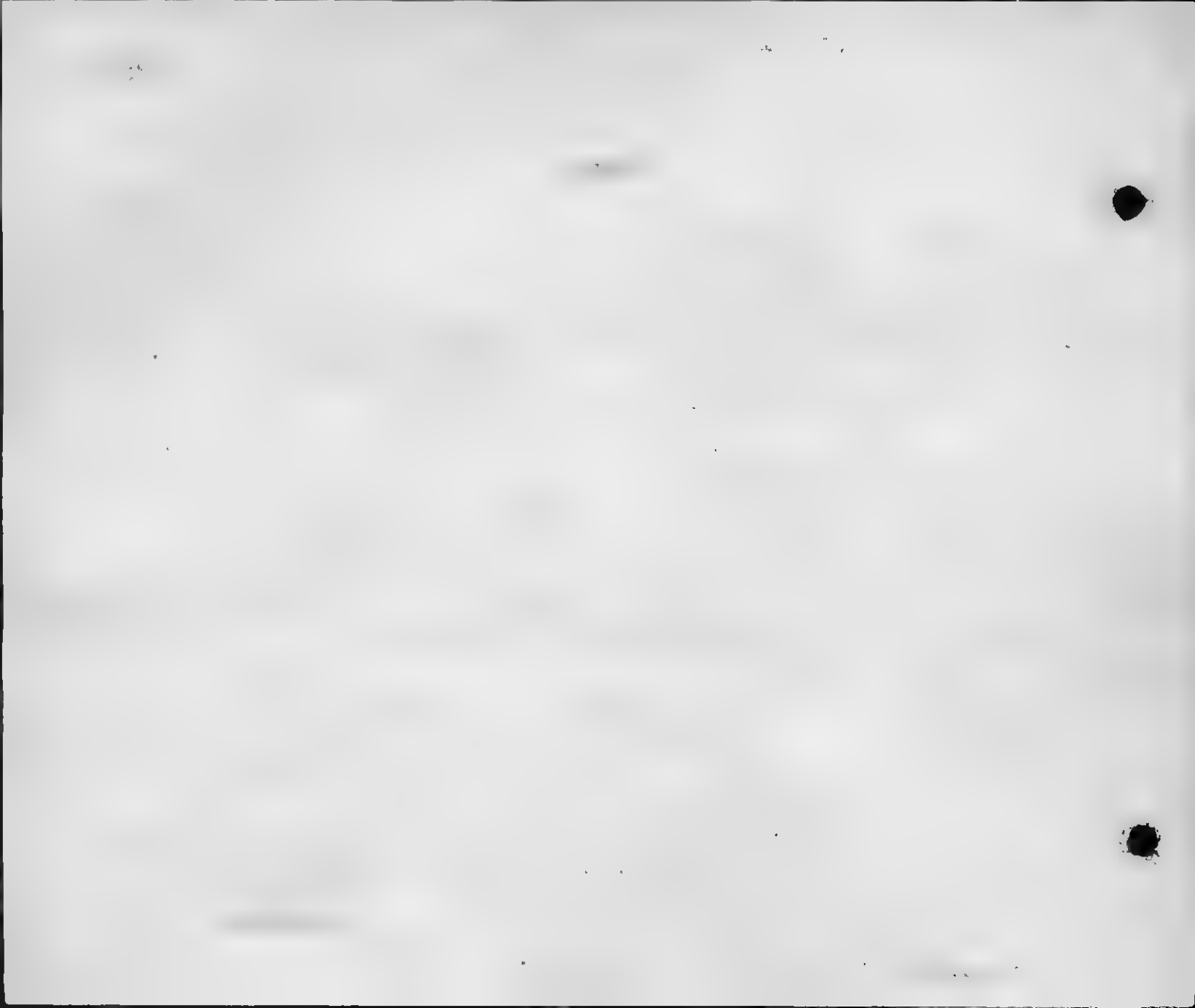


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09990

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>7mth20dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1227 Hesse Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Adeline</u> First Middle Last		4. DATE OF DEATH <u>September 1 1961</u> Month Day Year	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25, 1913</u> yrs. Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Georgett Herbert</u> 14. MOTHER'S M A D E N NAME <u>Bertha Spath</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Herbert Shoemaker - 1227 Hesse Ave. Baltimore</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Myocardial degeneration and replacement fibrosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, paranoid type</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (this hospital) attended the deceased from <u>Jan. 11, 1961</u> to <u>Sept. 1, 1961</u> that (I) (we) last saw the deceased alive on <u>Sept. 1, 1961</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Stella Wachslar</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22b. DATE SIGNED <u>9-1-61</u> 22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville 28, Maryland</u> <u>Stammers Run</u> <u>Golden Ring</u> Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-4-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Cemetery</u> 23d. LOCATION (City, town or county) <u>Golden Ring</u> (State) <u>Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll Funeral Home</u> 25. REC'D BY REGISTRAR <u>SEP 5 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



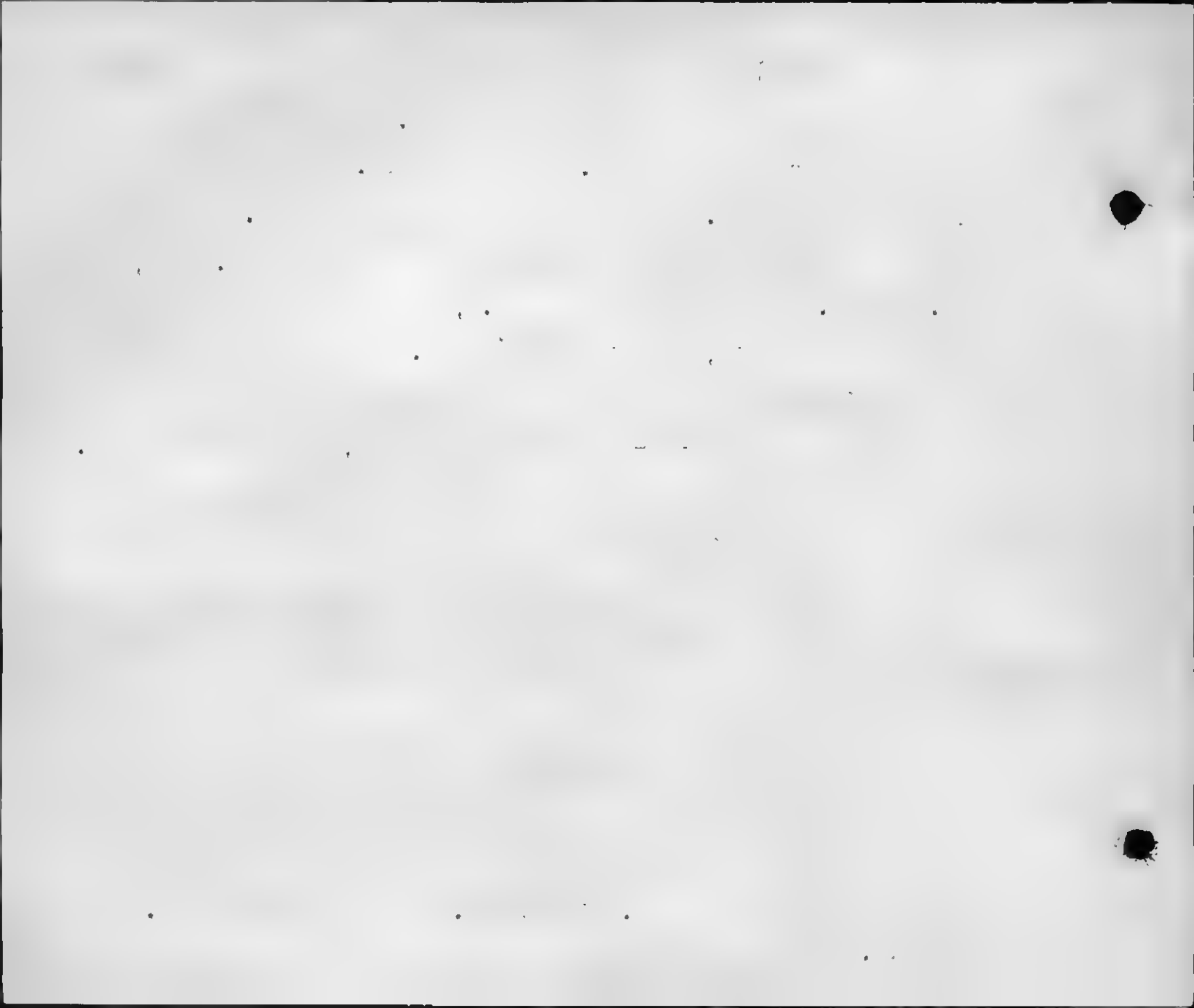
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2 9998

09991

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 21 Mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1033 Marksworth Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1033 Marksworth Rd. d. STREET ADDRESS 1033 Marksworth Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Smith Edward Singhass		4. DATE OF DEATH Sept. 11, 1961	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1883
9. AGE (in years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired auto mechanic, Atlantic Coast		10b. KIND OF BUSINESS OR INDUSTRY Auto	
11. FATHER'S NAME Singhass		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Singhass		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-05-1610	
17. INFORMANT Mrs. Henry Iager, 1033 Marksworth Rd.		Address 1033 Marksworth Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 1 PM + (c) 1 PM +		INTERVAL BETWEEN ONSET AND DEATH 1 PM +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2 AM , 19 60 to 9/11 , 19 61 , that (I) (we) last saw the deceased alive on 9/10 , 19 61 , and that death occurred at 3 AM , from the causes and on the date stated above.			
22a. SIGNATURE Thos E Roach		22b. DATE SIGNED 9/12/61	
22c. PHYSICIAN'S NAME (Type) Thos E Roach		22d. ADDRESS 5550 Balto Nat'l Pike - 28	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cmty.	23d. LOCATION (City, town or county) (State) Randallstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR SEP 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

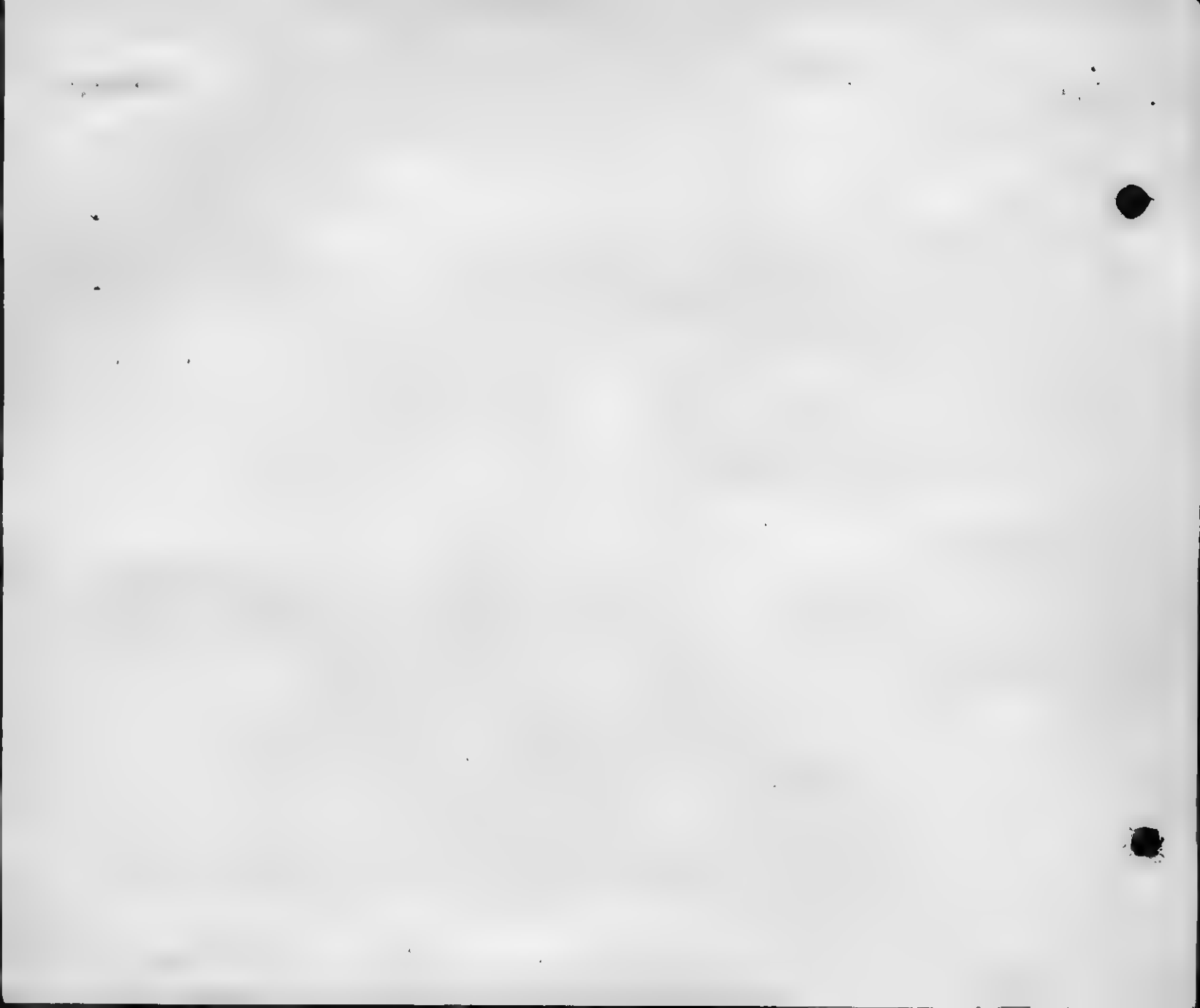
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0999

09993

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>4mth2dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Rural, urban, or suburban season) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>319 East Fort Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maggie</u> 4. DATE OF DEATH <u>Sept 17 1961</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 1, 1888</u> 9. AGE (In years, last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypostatic pneumonia</u> <u>Circulatory disturbances</u> <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between ONSET AND DEATH</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>325 PM</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>May 3, 1961</u> to <u>Sept 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 17, 1961</u> , and that death occurred at <u>325 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jose R. Arizaga, M.D.</u> 22b. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>		22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-20-61</u> 23b. DATE THEREOF <u>4-20-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. 130 E. Fort Ave.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

10000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>109 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Vetera's Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; if not, give street address) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 17</u> d. STREET ADDRESS <u>1728 Presbury Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEROY</u> First Middle Last 4. DATE OF DEATH <u>September 17 1961</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> B. DATE OF BIRTH <u>November 11, 1895</u> Yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Austin Smith</u> 14. MOTHER'S MAIDEN NAME <u>Ada Britton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>217-09-5935</u> 17. INFORMATION <u>Clinical Records, VA Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ANAPLASTIC CARCINOMA, LEFT LUNG WITH WIDESPREAD METASTASIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>163X</u> (b) <u>DOUE TO</u> (c) <u>ABSCCESS, LEFT LUNG; DIABETES MELLITUS; ARTERIOSCLEROSIS, GENERALIZED</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 31 1961</u> , to <u>Sept 17 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept 17 1961</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>C. M. Snyder M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>C. M. SNYDER M.D.</u>		22b. DATE SIGNED <u>9-17-61</u> 22d. ADDRESS <u>VAH Baltimore Md - Ft Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-21-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Kelson</u> 25a. REC'D BY REGISTRAR <u>SEP 19 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10001

Reg. Dist. No.

099994

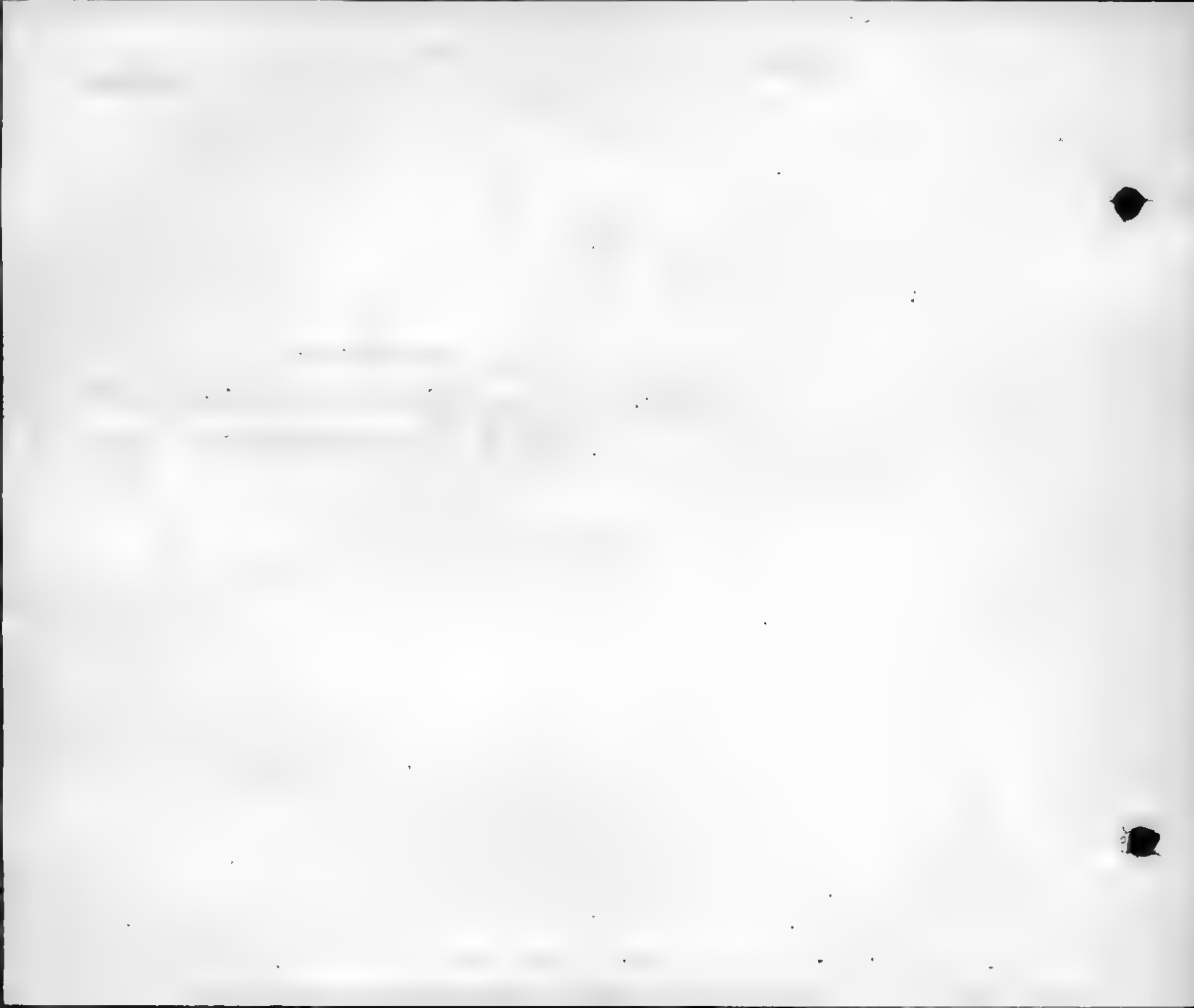
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9437 Ridgely Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>May</u> Middle <u>Smith</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1884</u> 77 yrs
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	11. IF UNDER 24 HRS Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William R. RYAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. MAHARER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>MRS LEONARD BAUBILITY SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>Sept. 9, 1961</u> , that I last saw the deceased alive on <u>Sept. 9, 1961</u> , and that death occurred at <u>9 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Jandorf</u> M.D.		ADDRESS (Street, city or town, state) <u>6077 Harford Rd</u> DATE SIGNED <u>9-9-61</u>	
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>		<u>Balto. 14, Md</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belair Mem.</u>	22d. LOCATION (City, town, or county) (State) <u>Belair Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. RUCK</u> ADDRESS <u>5305 HARFORD RD.</u>		24a. REC'D BY REGISTRAR <u>SEP 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>C. J. H. H.</u>

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10002

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence is not to be filled in) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cowleys Mills</u>		c. LENGTH OF STAY IN 1b <u>4 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Toy Snyder</u>		4. DATE OF DEATH Month Day Year <u>September 12 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>W.S.A.</u>	
13. FATHER'S NAME <u>Richard Andrews Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Howell Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Rosewood Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia complicating hydro-cephalus.</u> 344.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Sept 14 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons</u>		25a. REC'D BY REGISTRAR <u>SEP 18 '61</u>	
ADDRESS <u>Tristertown Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

2247292 XVI



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10003

CERTIFICATE OF DEATH

000006

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4400 Kenwood Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE		First CARRIE		Middle SOUDERS	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 26, 1879		9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Barton		14. MOTHER'S MAIDEN NAME Margaret Glacrin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Georgiana Greenwood 4400 Kenwood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) Coronary Thrombosis. Arteriosclerotic Cardio-Vascular Disease & Cardiac Insufficiency.		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8/7, 1961	
20f. (City or town) Baltimore		(County) Baltimore		(State) Md.	
21. I certify that (I) (the hospital) attended the deceased from 8/7, 1961 to 8/24, 1961 that (I) (we) last saw the deceased alive on 8/19, 1961 , and that death occurred at 8/24, 1961 from the causes and on the date stated above.		22a. SIGNATURE L. S. STEVENS M.D.		22b. DATE SIGNED 8/24, 1961	
22c. PHYSICIAN'S NAME (Type) L. S. STEVENS M.D.		22d. ADDRESS 3400 Erdman Ave - 13, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL - CREMATION - REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 9/27/61		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23d. LOCATION (City, town, or county) Baltimore County, Md.		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 4210 Belair Rd. 6		25a. REC'D BY REGISTRAR SEP 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

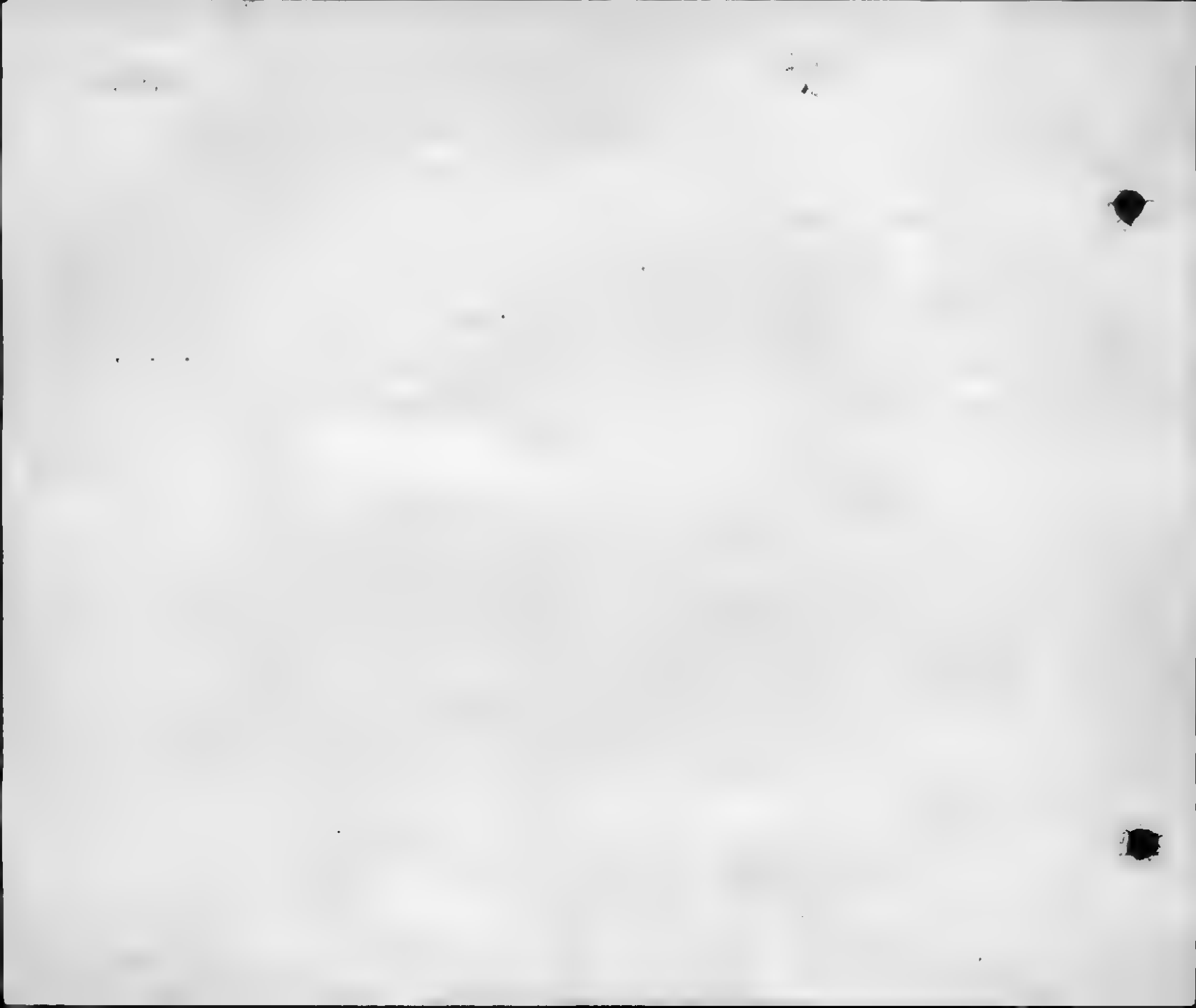
10004

09997

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institution; residents before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>5635 Oakland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis A. Stiles</u>		4. DATE OF DEATH <u>September 27 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1891</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired glass worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>	
13. FATHER'S NAME <u>Isaac Stiles</u>		14. MOTHER'S MAIDEN NAME <u>Sarah White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mrs. Elizabeth Stiles -5635 Oakland Road #27</u>		Address <u>_____</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO (b) <u>chronic myocardial disease</u> DUE TO (c) <u>general atherosclerosis</u> (e), stating the underlying cause last. <u>arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1960</u> to <u>Sept 27 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 27 1961</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>B B Brumbaugh M.D.</u>		22b. DATE SIGNED <u>9/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		22d. ADDRESS <u>1609 Main St Elkridge Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-30-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Elkridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons</u>		25a. REC'D BY REGISTRAR <u>SEP 29 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Travis</u>		25c. ADDRESS <u>_____</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as file burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

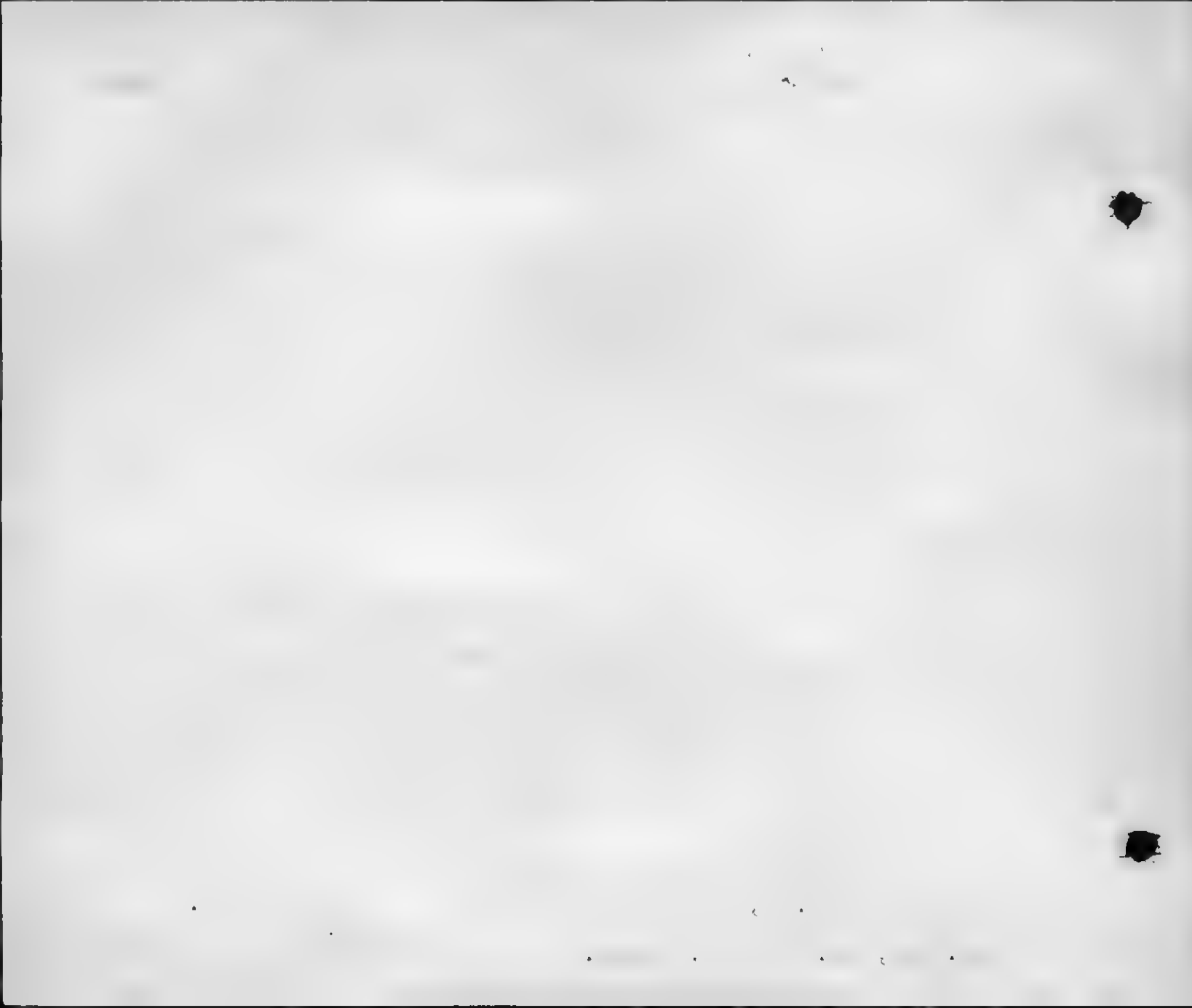


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MD
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10005
09998
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions; not applicable to a mission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 7 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MASONIC HOME		d. STREET ADDRESS 1602 FREDERICK RD.	
3. NAME OF DECEASED (Type or print) First JAMES Middle W Last STODDARD		4. DATE OF DEATH Month SEPT Day 13 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1866
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DANIEL STODDARD		14. MOTHER'S MAIDEN NAME MARY MYERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Paul L. Smith Jr. - Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-2 , 1954, to 9-13 , 1961, that (I) (we) last saw the deceased alive on 9-13 , 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees M.D.			
22b. DATE SIGNED 9/13/61			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES			
22d. ADDRESS COCKEYSVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Sept. 16, 1961			
23c. NAME OF CEMETERY OR CREMATORY Loudon Park			
23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. ADDRESS 1217 St. Paul St.			
25a. REC'D BY REGISTRAR SEP 15 1961			
25b. REGISTRAR'S SIGNATURE Charles L. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10006

09999

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1222 Division Street - 17</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ASHBY</u> First Middle Last		4. DATE OF DEATH <u>September 4, 1961</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1893</u>	
9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rockbridge Co. Virginia</u>	
13. FATHER'S NAME <u>Samuel Stoops</u>		14. MOTHER'S MAIDEN NAME <u>Mary MN: Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW-1</u>		16. SOCIAL SECURITY NO <u>218-05-6853</u>	
17. INFORMATION <u>Clinical Records, VA Hospital, 3900 Loch Raven Blvd. Balto 18, Md-FORT HOWARD DIV.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF LIVER</u> (b) <u>BRONCHOPNEUMONIA</u> (c) <u>DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY - 4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 25, 1961</u> to <u>September 4, 1961</u> that (X) (we) last saw the deceased alive on <u>Sept. 4, 1961</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Sebastian Russo</u>		22b. DATE <u>9/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>		22d. ADDRESS <u>VAH, BALTO 18, MARYLAND, FT. HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>SEP 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Baltimore</u> <u>Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 7 61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and complete, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 10007
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 8 yrs.		d. STREET ADDRESS 5213 Biddison Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Agatha Last Sughrue		4. DATE OF DEATH Month Sept. Day 12 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 8 Days 12 Hours 12 Min.	11. IF UNDER 24 HRS Months 8 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Sughrue		14. MOTHER'S MAIDEN NAME Margaret Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 1.010	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Exhaustion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) ASCD			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 5:15 A.M. to Sept. 1961 that (I) (we) last saw the deceased alive on Sept. 9 1961 , and that death occurred at M. from the causes and on the date stated above			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D.		22d. ADDRESS 602 E. Joppa Rd. Towson, Md.	
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/15/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward J. Rude		25. REGISTRAR'S SIGNATURE Barbara Rude	
25a. REC'D BY REGISTRAR SEP 20 1961		25b. REGISTRAR'S SIGNATURE Barbara Rude	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10008.

10001

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9240 Smith Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Samuel S Tagg				4. DATE OF DEATH Month Day Year 9 23 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-1859	
9. AGE (In years last birthday) 101 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Ethelbert Tagg			
14. MOTHER'S MAIDEN NAME Elizabeth Stallings				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214-14-8864				17. INFORMANT Mrs Naomie Wright Address 9240 Smith Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-211 DUE TO Arteriosclerosis, atherosclerosis, chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 12, 1952 to July 19, 1961 , that (I) (we) last saw the deceased alive on July 19, 1961 , and that death occurred at 12:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE Elliot Harris M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/23/61	
22c. PHYSICIAN'S NAME (Type) Dr Elliot Harris				22d. ADDRESS 1100 Hospital Bldg., Baltimore 18, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-1961		23c. NAME OF CEMETERY OR CREMATORY Hiss Meth Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore 6 Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home ADDRESS 7401 Belair Road				25a. REC'D BY REGISTRAR DATE 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Form 6205 3/10/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

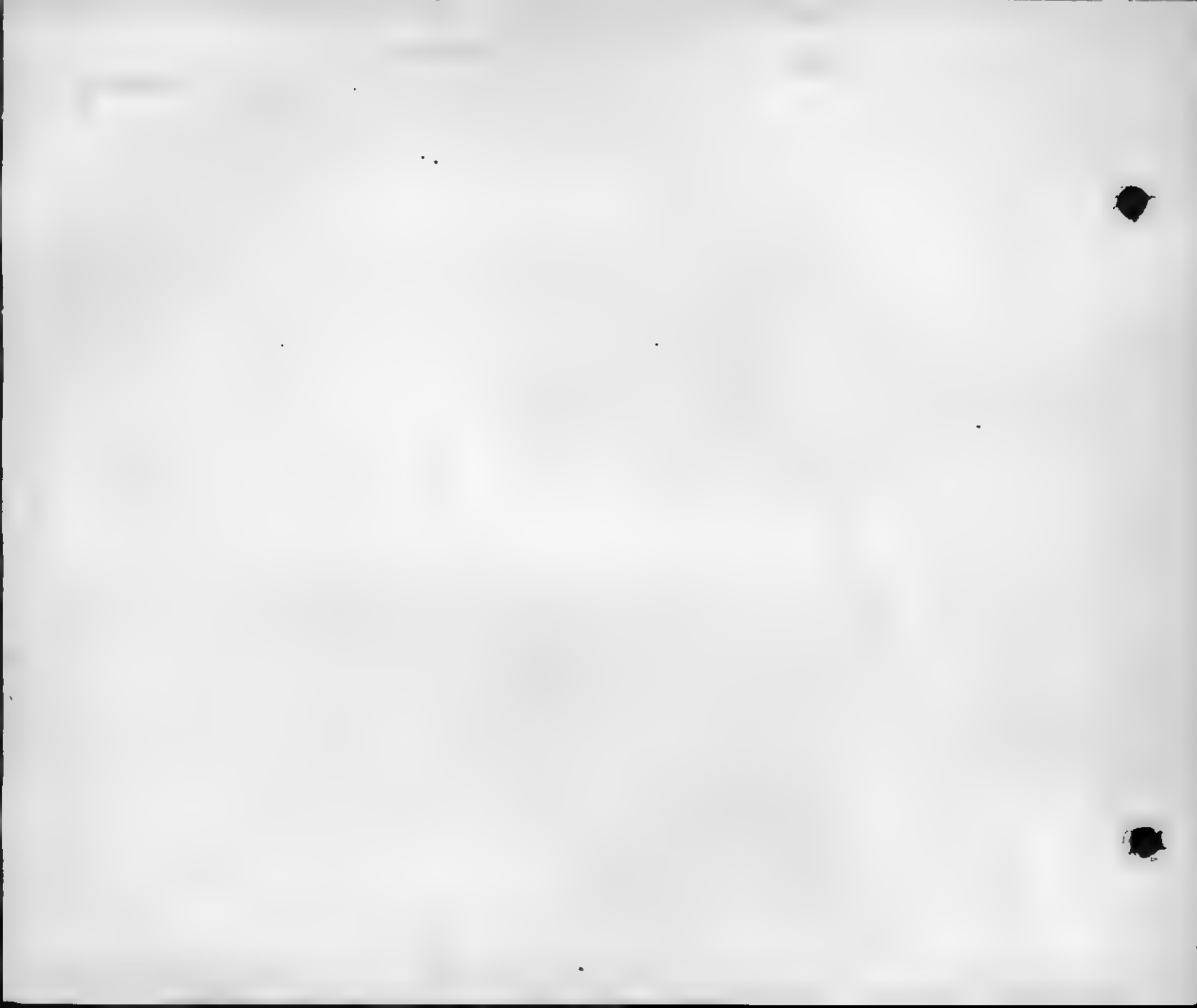
10009

10009

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>15 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4458 BEARSHIRE</u>				d. STREET ADDRESS <u>17458 BEARSHIRE RD.</u>			
3. NAME OF DECEASED (Type or print) First <u>EMILE</u> Middle <u>J.</u> Last <u>THIBAUT</u>				4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JAN. 13, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METAL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN CO</u>		11. BIRTHPLACE (State or foreign country) <u>AMESBURY MASS.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>XAVIER Thibault</u>					
14. MOTHER'S MAIDEN NAME <u>MARIE LEVEQUE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>					
16. SOCIAL SECURITY NO. <u>317-10-3333</u>		17. INFORMANT <u>LORETTE THIBAUT (AS ABOVE)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.I. hematology</u> DUE TO <u>Esophageal varices</u> (b) <u>Cirrhosis of liver</u> DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from _____ 19 <u>52</u> , to _____ 19 <u>61</u> , that I last saw the deceased alive on _____ 19 <u>61</u> , and that death occurred at _____ 7 A. M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. P. LATT, M.D.</u>		ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u>		DATE SIGNED <u>9/8/61</u>			
PHYSICIAN'S NAME (Type) <u>J. P. LATT, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					
22b. DATE THEREOF <u>9/13/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Delorski</u>		ADDRESS <u>1005 DUNDALK AV.</u>		24a. REC'D BY REGISTRAR <u>SEP 11 61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G296 9/28/61 iwk

CERTIFICATE OF DEATH

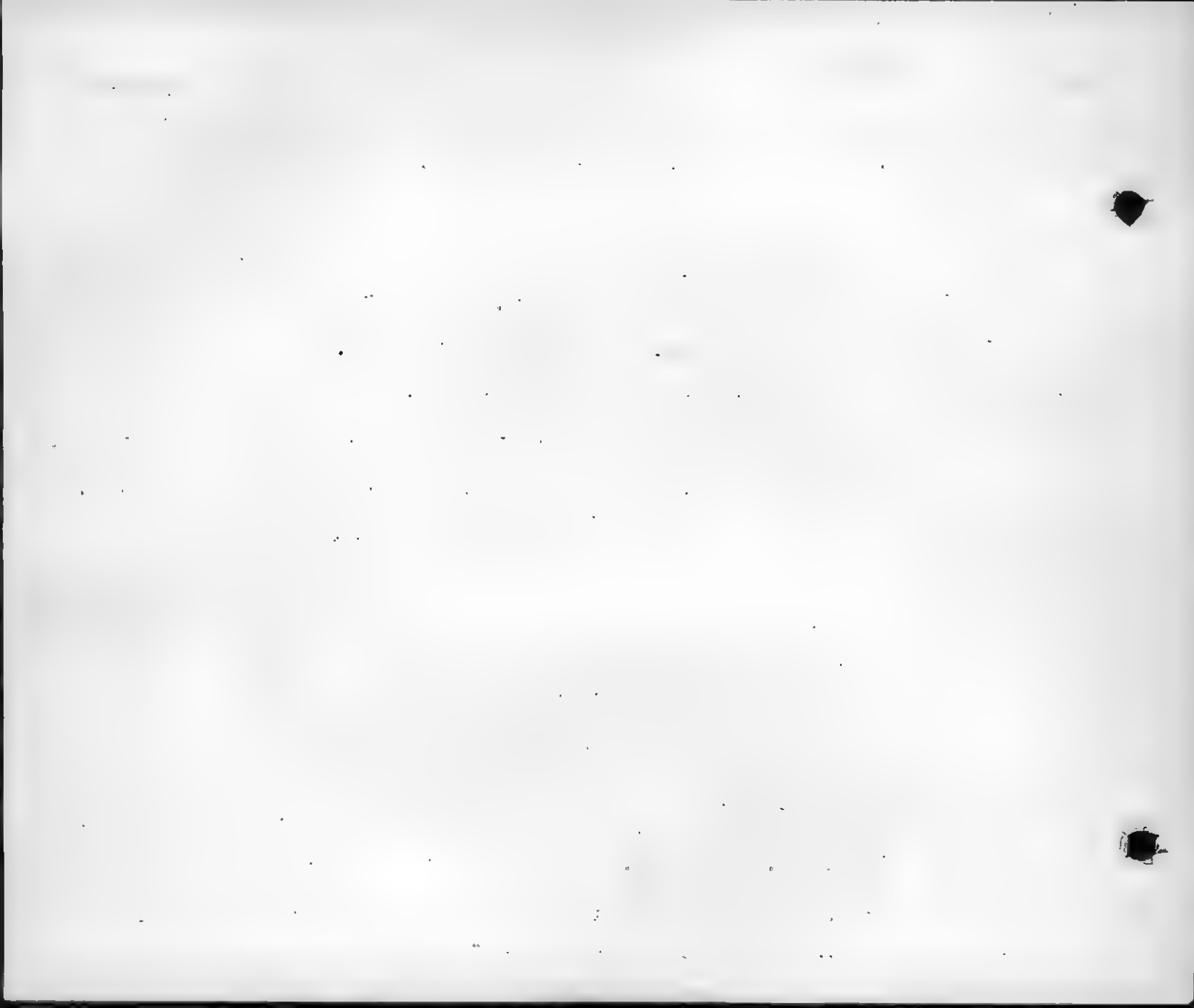
Reg. Dist. No.

10010

10003

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Transit d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 147				2. USUAL RESIDENCE (Where deceased lived. If institution, Resident, board, or institution) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville d. STREET ADDRESS 12X-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Shepherd Last Thomas			4. DATE OF DEATH Month Sept. Day 22, Year 19 61				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1878		9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 82 Days 22 Hours 19 Min 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Monkton, Md.			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Winfield Shepherd			14. MOTHER'S MAIDEN NAME Ida Bacon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		INFORMANT Address Walter E. Thomas Jarrettsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro - Vascular accident DUE TO Hypertensive Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO --- (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. INTERVAL BETWEEN ONSET AND DEATH One hour 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) no injury					
20c. TIME OF INJURY Month, Day, Year Hour a. m. X p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X			
20f. (City or town) X		20g. (County) X		20h. (State) X			
21. I certify that I attended the deceased from May 1961 , to September 1961 , that I last saw the deceased alive on September 22 , 19 61 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James F. White, Jr.		ADDRESS (Street, city or town, state) Jarrettsville, Md.		DATE SIGNED 9/23/61			
PHYSICIAN'S NAME (Type) James F. White Jr.		Jarrettsville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/1961		22c. NAME OF CEMETERY OR CREMATORY Jarrettsville			
22d. LOCATION (City, town, or county) Jarrettsville, Maryland		22e. (State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kutz		ADDRESS Jarrettsville, Md.		24a. REC'D BY REGISTRAR SEP 26 '61			
24b. REGISTRAR'S SIGNATURE Charles C. Kutz							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10011

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 400 OAK COURT		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 400 OAK COURT	
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHEA C. THOMPSON		4. DATE OF DEATH Month Day Year SEPT. 10 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 17, 1921
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days 	
11. IF UNDER 24 HRS. Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ESTIMATOR		14. KIND OF BUSINESS OR INDUSTRY PRINTING CO.	
15. BIRTHPLACE (County & State or foreign country) NEW JERSEY		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. FATHER'S NAME GERALD E. COURTNEY		18. MOTHER'S MAIDEN NAME DOROTHY SMITH	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		20. SOCIAL SECURITY NO. 	
21. INFORMANT Address William H. Thompson - 400 Oak Court		22. INTERVAL BETWEEN ONSET AND DEATH May 6	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 			
24. MEDICAL CERTIFICATION 24a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 24c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 24d. INJURY OCCURRED While at work Not While at work 24e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 24f. (City or town) (County) (State) 			
25. I certify that (I) (this hospital) attended the deceased from 1958 , 19 , to Sept 10 , 1961, that (I) (we) last saw the deceased alive on August 30, 1961 , and that death occurred at 6 PM , from the causes and on the date stated above.			
26. SIGNATURE John A. Nesbitt Jr.		27. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 28. ADDRESS 1118 St Paul St, Baltimore 2, Md.	
29. BURIAL, CREMATION, REMOVAL (Specify) Burial		30. DATE THEREOF Sept. 13, 1961	
31. NAME OF CEMETERY OR CREMATORY Lanier Ridge Cem.		32. LOCATION (City, town or county) (State) Catonville Md.	
33. FUNERAL DIRECTOR'S SIGNATURE Harley C. Cronough - F.A. - Catonsville, Md.		34. REC'D BY REGISTRAR DATE SEP 14 '61	
35. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

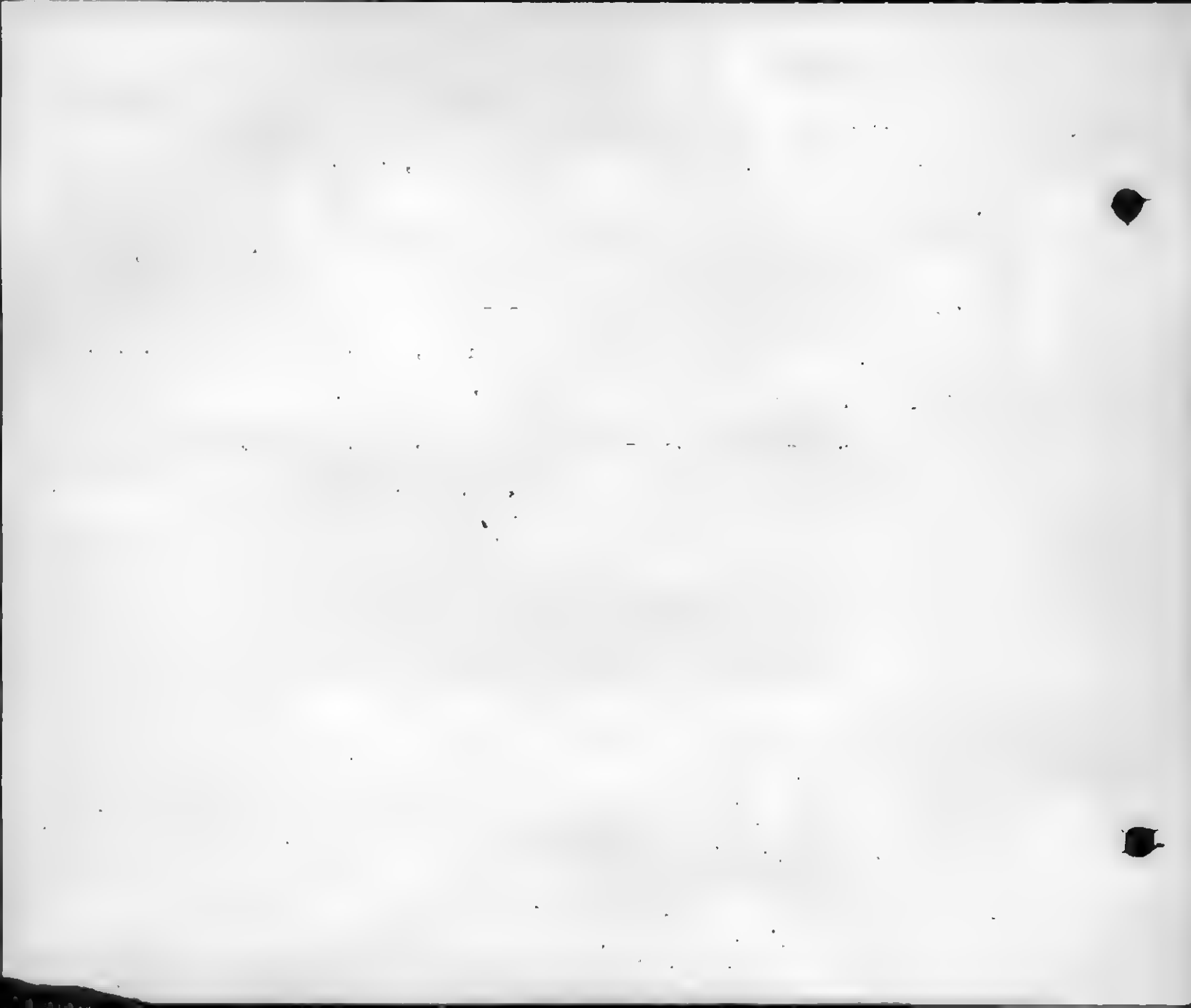
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2019 Hillcrest Road		d. STREET ADDRESS 2019 Hillcrest Road	
3. NAME OF DECEASED (Type or print) Mildred Harvey Thomsen		4. DATE OF DEATH Month September Day 10 Year 1964	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1901
9. AGE (In years lost birthday) 60 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steongrapher	11. BIRTHPLACE (State or foreign country) Olney, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William W. Harvey	
14. MOTHER'S MAIDEN NAME Macie Pricew		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 216-24-1713		17. ADDRESS Jes Hygum Thomsen 2019 Hillcrest Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of ribs, left lung & pelvis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Carcinoma of left breast DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mos. 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/7 , 1959, to 9/10 , 1964, that I last saw the deceased alive on 9/8 , 1964, and that death occurred at 6:40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert J. Schochat		DATE SIGNED 4/11/64	
PHYSICIAN'S NAME (Type) Albert J. Schochat M.D.		1300 2nd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/13/61	22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	22d. LOCATION (City, town, or county) (State) Olney, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR DATE SEP 13 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

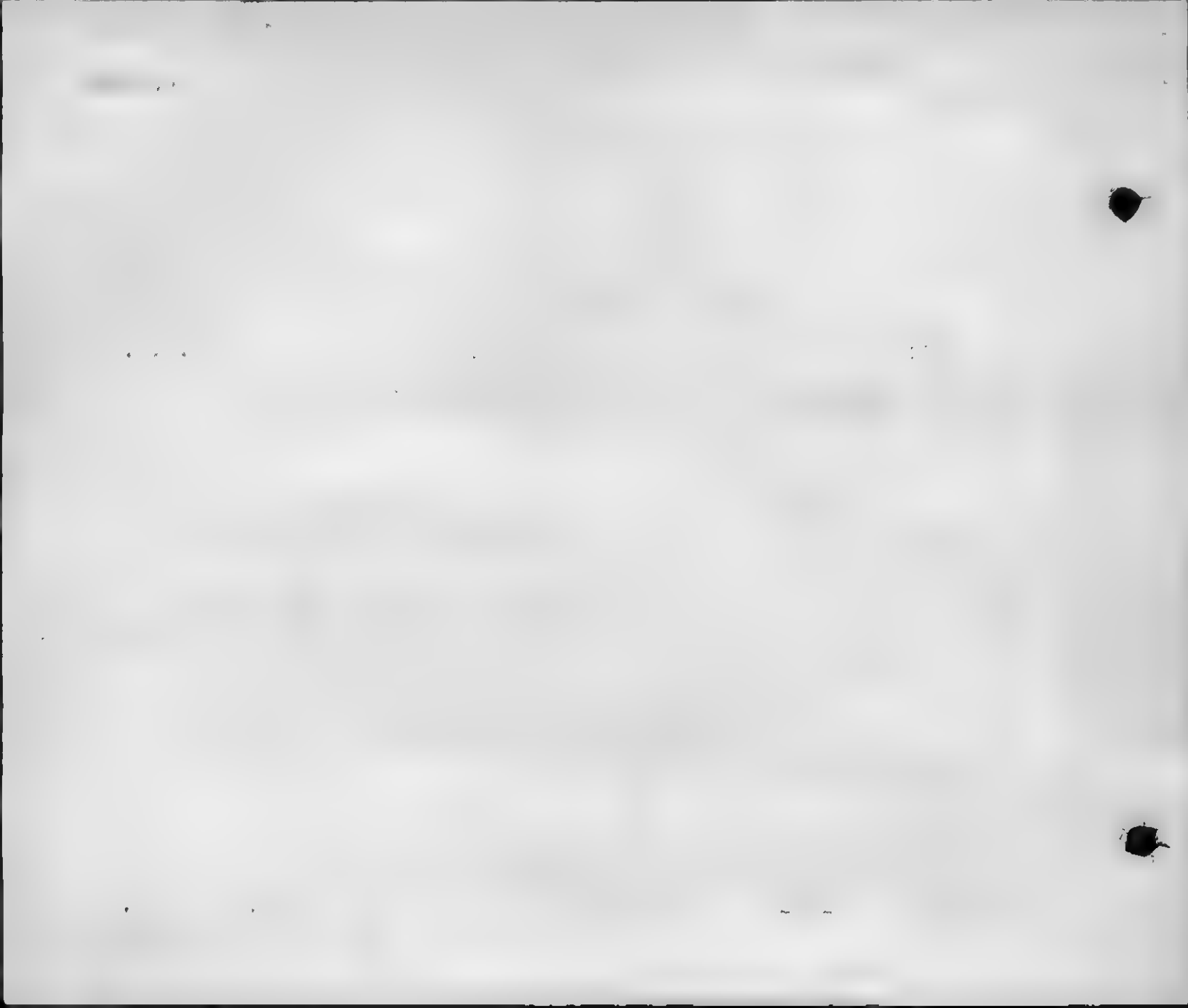
(I)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10013 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10006

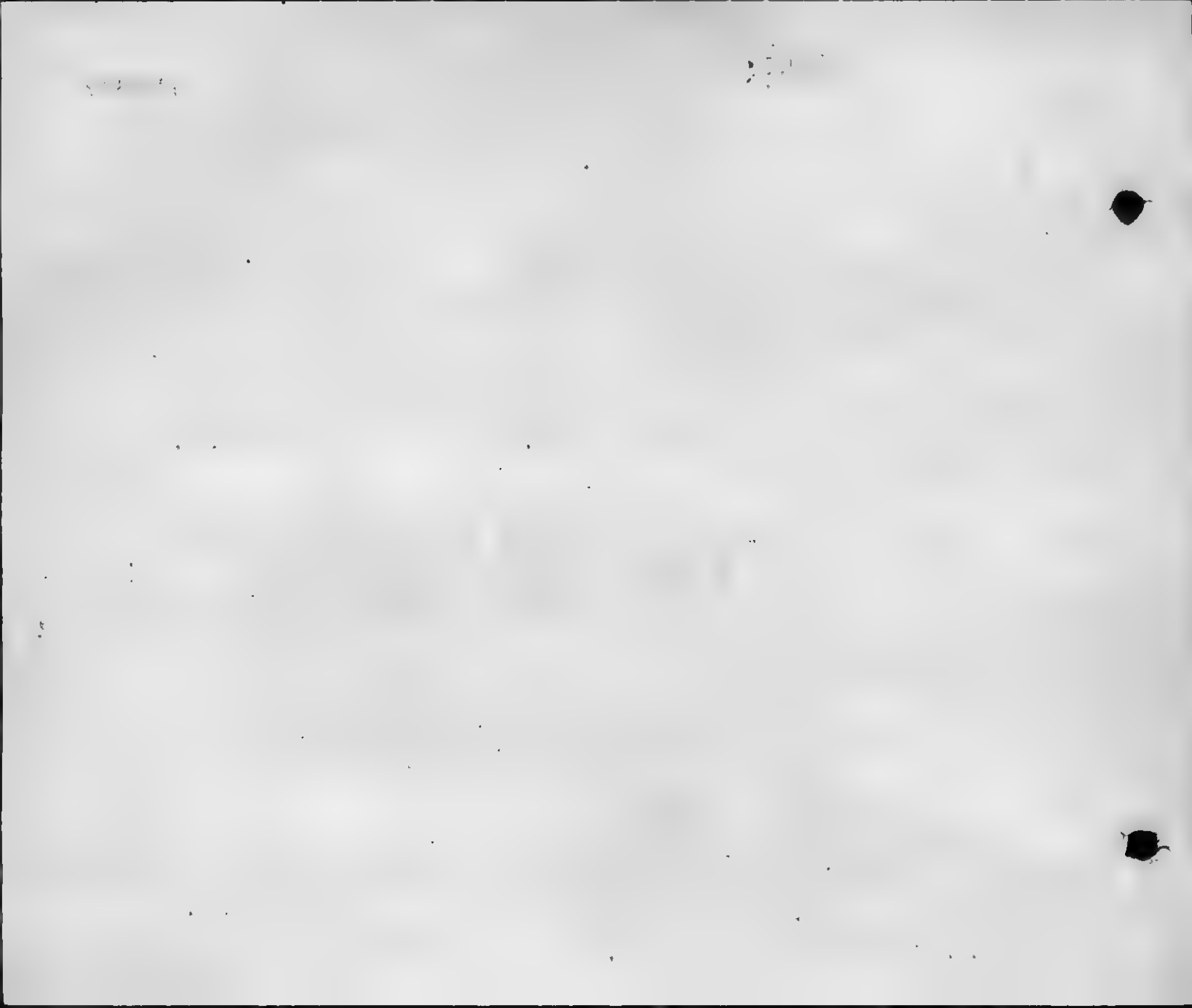
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, last residence before admission) e. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Brentwood Home</i>		d. STREET ADDRESS <i>4010 Clifton Ave - Balt 16</i>	
3. NAME OF DECEASED (Type or print) <i>JOHN</i>	4. DATE OF DEATH <i>Sept 21 1961</i>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	b. DATE OF BIRTH <i>July 29 1882</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <i>79</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butler</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Tilghman</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Paraway</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Brentwood Home - Reisterstown</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422</i> <i>Pneumonia (Bilateral)</i> DUE TO (b) <i>arteriosclerosis & v. disease</i> DUE TO (c) <i>fracture left hip</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <i>fracture left hip</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18) <i>Fall from steps</i>	
20c. TIME OF INJURY Month, Day, Year <i>5-3 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-25-61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem</i>		22d. LOCATION (City, town, or country) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR <i>Mrs. Francis A. Hensley</i>		24a. REC'D BY REGISTRAR <i>SEP 25 '61</i>	
ADDRESS <i>578 W. Biddle St</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Hensley</i>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10014
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon c. LENGTH OF STAY IN b 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Worthington Hill		2. USUAL RESIDENCE (Where deceased lived, if institutional residence, before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon d. STREET ADDRESS Worthington Hill e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie Miller Tovell		4. DATE OF DEATH Sept. 19, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1873
9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 8 Days 8	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Henry Miller		14. MOTHER'S MAIDEN NAME Sarah Algire	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Helen Tovell Reese, Glyndon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial decompensating (c) Coronary Insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Sudden 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-1930 to 9-19-61 , that (I) (we) last saw the deceased alive on 9-17-1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James G. Siffell M.D.		22b. DATE SIGNED 9-21-61	
22c. PHYSICIAN'S NAME (Type) James G. Siffell MD		22d. ADDRESS Reisterstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 22/61	23c. NAME OF CEMETERY OR CREMATORY All-Saints	23d. LOCATION (City, town or county) (State) Reisterstown, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		25. REC'D BY REGISTRAR SEP 25 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10015

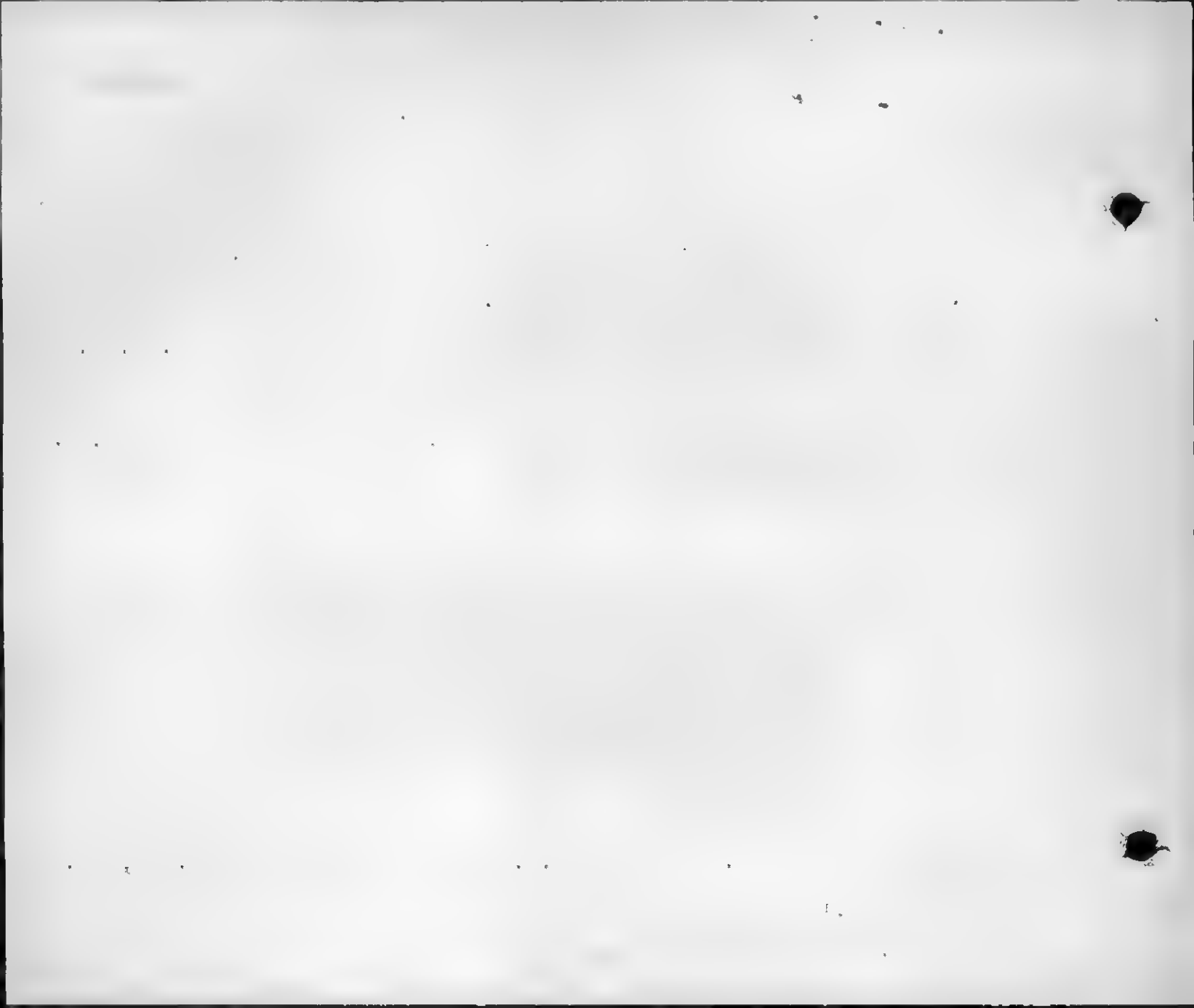
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10008

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2516 Washington Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Tschaksts (also John Schack)		4. DATE OF DEATH Month Day Year Sept. 10, 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 88	11. IF UNDER 24 HRS Months Days Hours Min 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired grocer		10b. KIND OF BUSINESS OR INDUSTRY Latvia	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Arnold E. Schack		Address 1601 Rolling Rd. #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD with DUE TO (c) central thrombosis and hemiparesis INTERVAL BETWEEN ONSET AND DEATH 3 days 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1961 to Sept 10, 1961 , that (I) (we) last saw the deceased alive on 9/10/61 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Herbert J. Levickas		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas, M.D.		22d. ADDRESS 5305 East Drive, Balto. 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/61	23c. NAME OF CEMETERY OR CREMATORY Western Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR SEP 13 '61	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

M



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10016

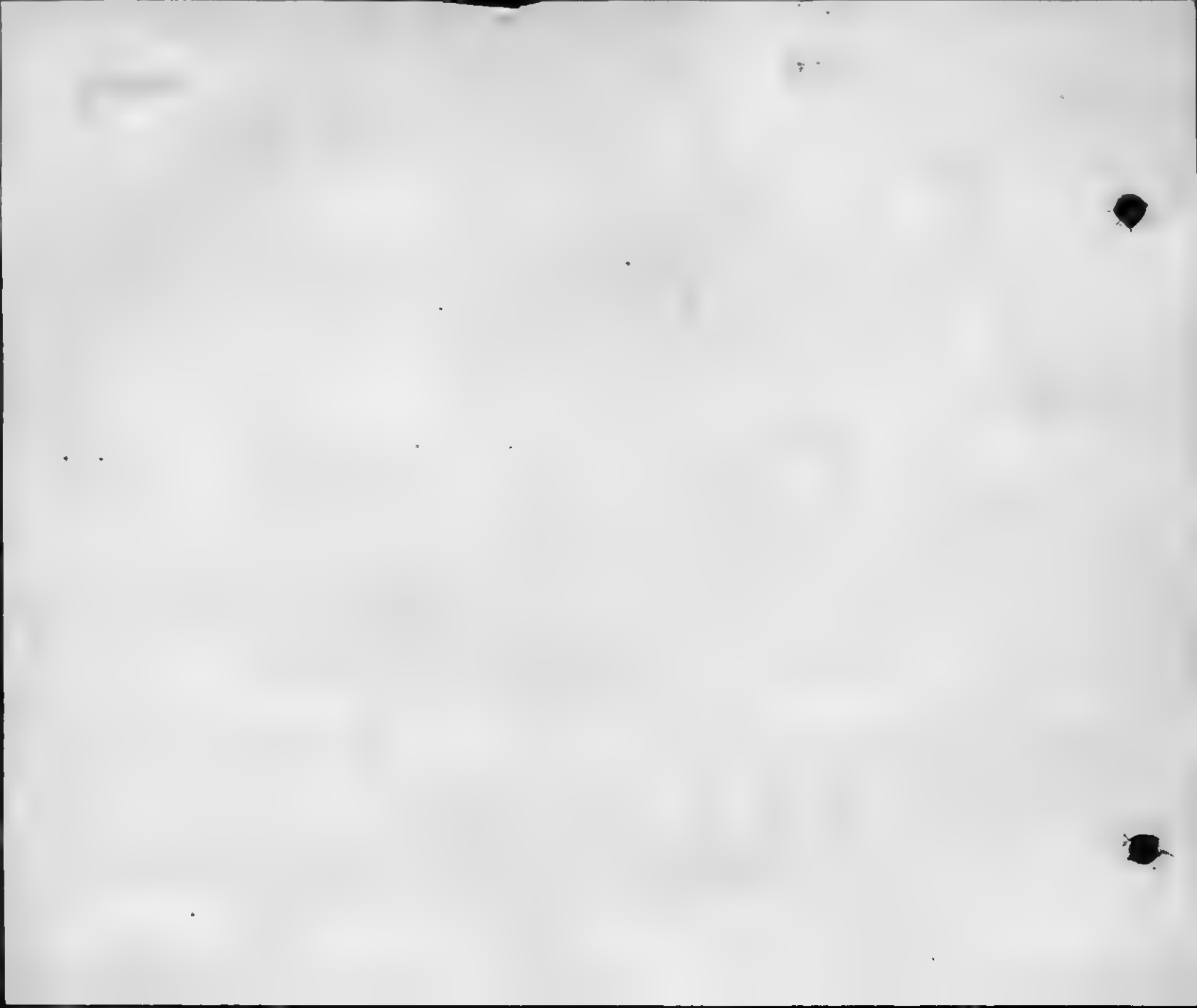
10009

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution and date of admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mercy Villa 6400 Pellona Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice M. Tucker</u>	4. DATE OF DEATH <u>September 22, 1961</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 16, 1981</u>	9. AGE (In years last birthday) <u>80</u> yrs.	10. MONTHS <u>4</u>	11. DAYS <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Charles Merritt</u>		14. MOTHER'S M.A.DEN NAME <u>Kate Lynch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John M. Tucker</u>		Address <u>80 Hance Road Fair Haven, N.J.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Cerebral Hemorrhage</u> (b) <u>Arterio-sclerosis</u> DUE TO <u>Myocarditis</u> (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 Days</u> <u>4-5 Days</u> <u>Gradual</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DATE SIGNED <u>Sept 22, 1961</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 22, 1961</u> to <u>Sept 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 22, 1961</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Woody</u>		22b. DATE SIGNED <u>Sept 22, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. H. Woody</u>		22d. ADDRESS <u>140 E Park Ave Baltimore, Md</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>9/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>William J. Tucker</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Tucker</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours after death, it may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10017

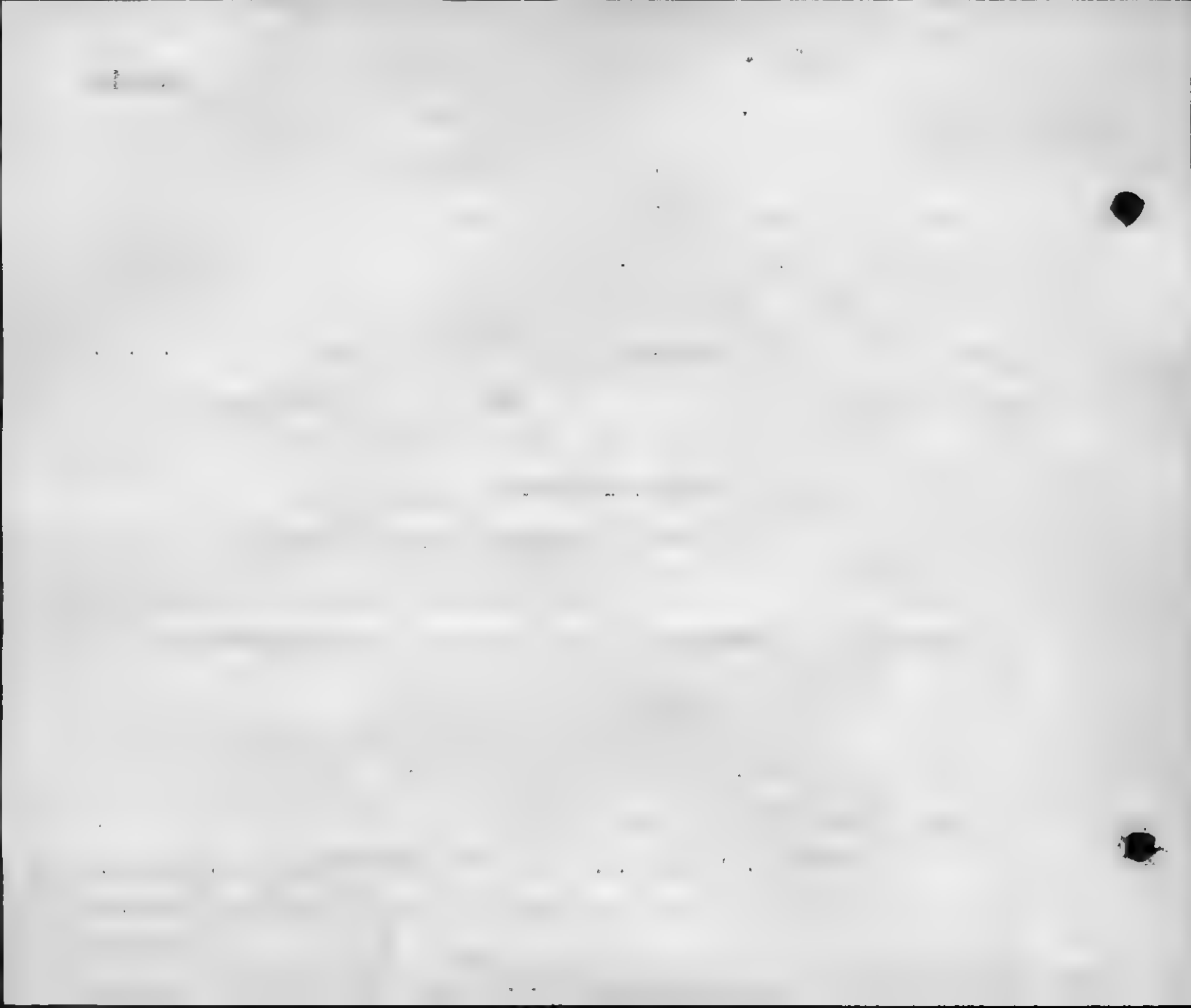
10010

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY in 1b 17 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Queen Annes c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Centreville d. STREET ADDRESS 208 Tillman Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRA G. UNSWORTH		4. DATE OF DEATH September 13 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1895
9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (County & State, or foreign country) Centreville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Unsworth		14. MOTHER'S MAIDEN NAME Alice MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 579-07-7829	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF TRANSVERSE COLON, POST OPERATIVE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation-9/13/61-Laparotomy, Small Bowel Resection and Entero-anastomosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS 4 WEEKS	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) August 27, 1961, to September 13, 1961	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 13, 1961 , and that death occurred at 11:25 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE 9/13/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9-16-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington 11, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.		25a. REGISTRY REQUESTED SEP 18 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

VR A15 (4)

15M 9/60

Shipped to W. W. Chambers, Chapin St., Washington D.C.

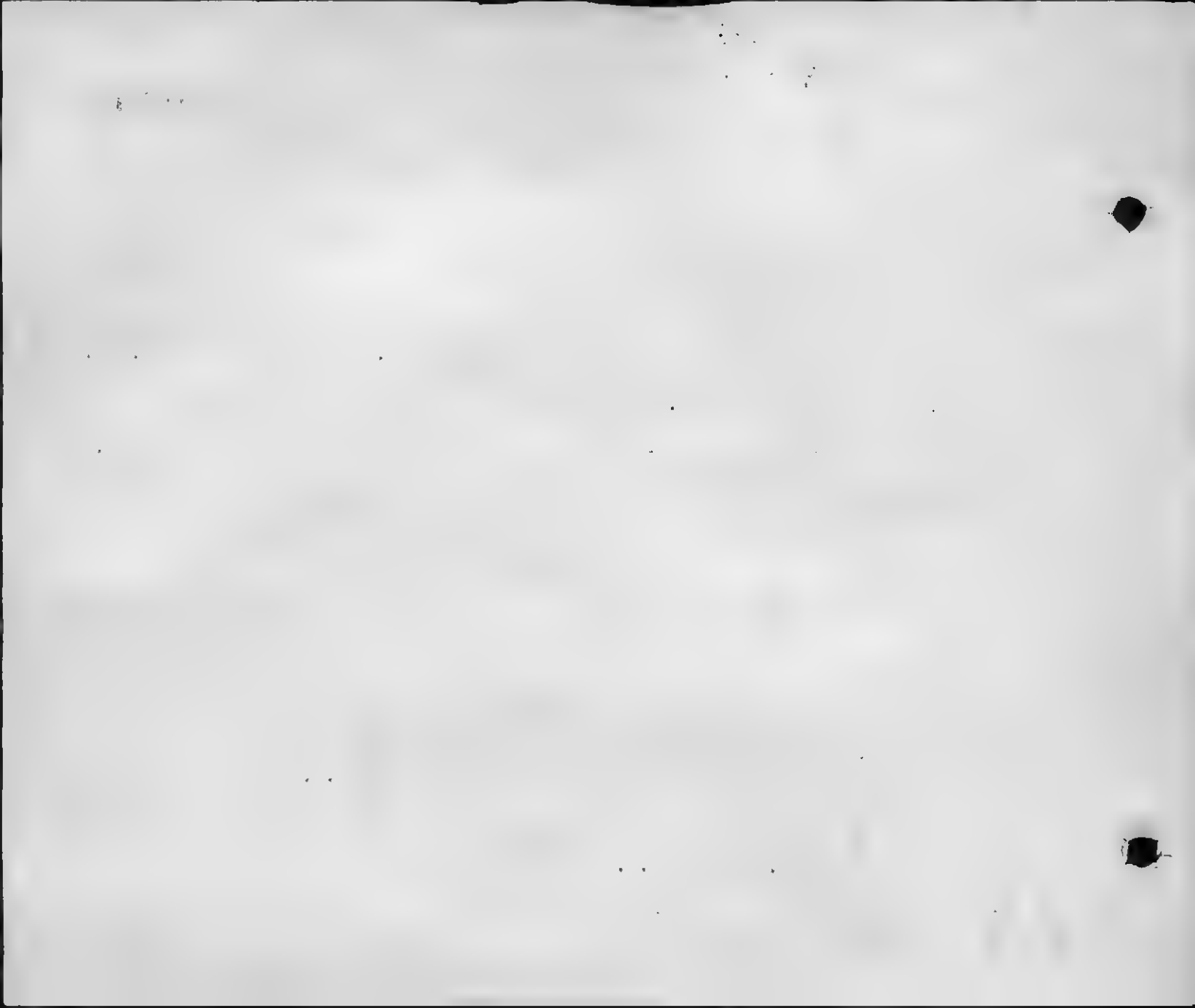


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived, if institutions, residence prior to admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) Warren Benjamin Wade First Middle Last		4. DATE OF DEATH Month 9 Day 28 Year 1961	
5. SEX Male 6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		11. BIRTHPLACE (County & State, or foreign country) Charles Co., Maryland	
13. FATHER'S NAME William Benjamin Wade, Jr.		14. MOTHER'S MAIDEN NAME Irma Marie Chapman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: (a) Bronchopneumonia due to undetermined cause (361 410) (b) Anauretic familial idiocy, Juvenile (902 9552) (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ---		12. CITIZEN OF WHAT COUNTRY U.S.A. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour --- a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (4) (this hospital) attended the deceased from 9/23 , 19 59 , to 9/28 , 19 61 , that (1) (we) last saw the deceased alive on 9/28 , 19 61 , and that death occurred at 10:45 from the causes and on the date stated above.			
22a. SIGNATURE Grange A. Coffin		22b. DATE SIGNED 9-29-61	
22c. PHYSICIAN'S NAME (Type) Grange A. Coffin, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/2/61	
23c. NAME OF CEMETERY OR CREMATORY Church am.		23d. LOCATION (City, town or county) (State) Bryantown Charles Co md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. B. Nelson		25a. REC'D BY REGISTRAR DATE OCT 2 '61	
25b. REGISTRAR'S SIGNATURE William B. Nelson		25c. ADDRESS 1347 N. Calhoun St	



CERTIFICATE OF DEATH

Reg. Dist. No.

10015

10012

PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence, birth, or admission)

a. STATE

Maryland

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural-Freeland

c. LENGTH OF STAY IN TB

70 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural-Freeland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Middletown Rd.

d. STREET ADDRESS

Middletown Rd

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

Graft

First

Middle

Last

Edward Walker

4. DATE OF DEATH

Month

Day

Year

Sept. 15,

1961

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

March 20, 1876

9. AGE (In years)

IF UNDER 1 YEAR

IF UNDER 24 HRS

yrs.

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Own Farm

11. BIRTHPLACE (State or foreign country)

Baltimore Co., Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Adam Walker

14. MOTHER'S MAIDEN NAME

Sarah Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

—

INFORMANT

Joseph Walker, Freeland, Md. R.D.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X DUE TO

Cerebral Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Hypertension
Arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH

10 hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.

19

20d. INJURY OCCURRED
While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 8/22, 1961 to 9/15, 1961 that I last saw the deceased alive on 9/15, 1961, and that death occurred at 4:00 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE

A. M. France

ADDRESS (Street, city or town, state)

PARKTON, Md

DATE SIGNED

9/16/61

PHYSICIAN'S NAME (Type)

A. M. FRANCE

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-18-61

22c. NAME OF CEMETERY OR CREMATORY

Middletown Cemetery

22d. LOCATION (City, town, or county)

Freeland, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Joseph Walker, New Freedom, Pa.

ADDRESS

New Freedom, Pa.

24a. REC'D BY REGISTRAR

DATE 9 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. French

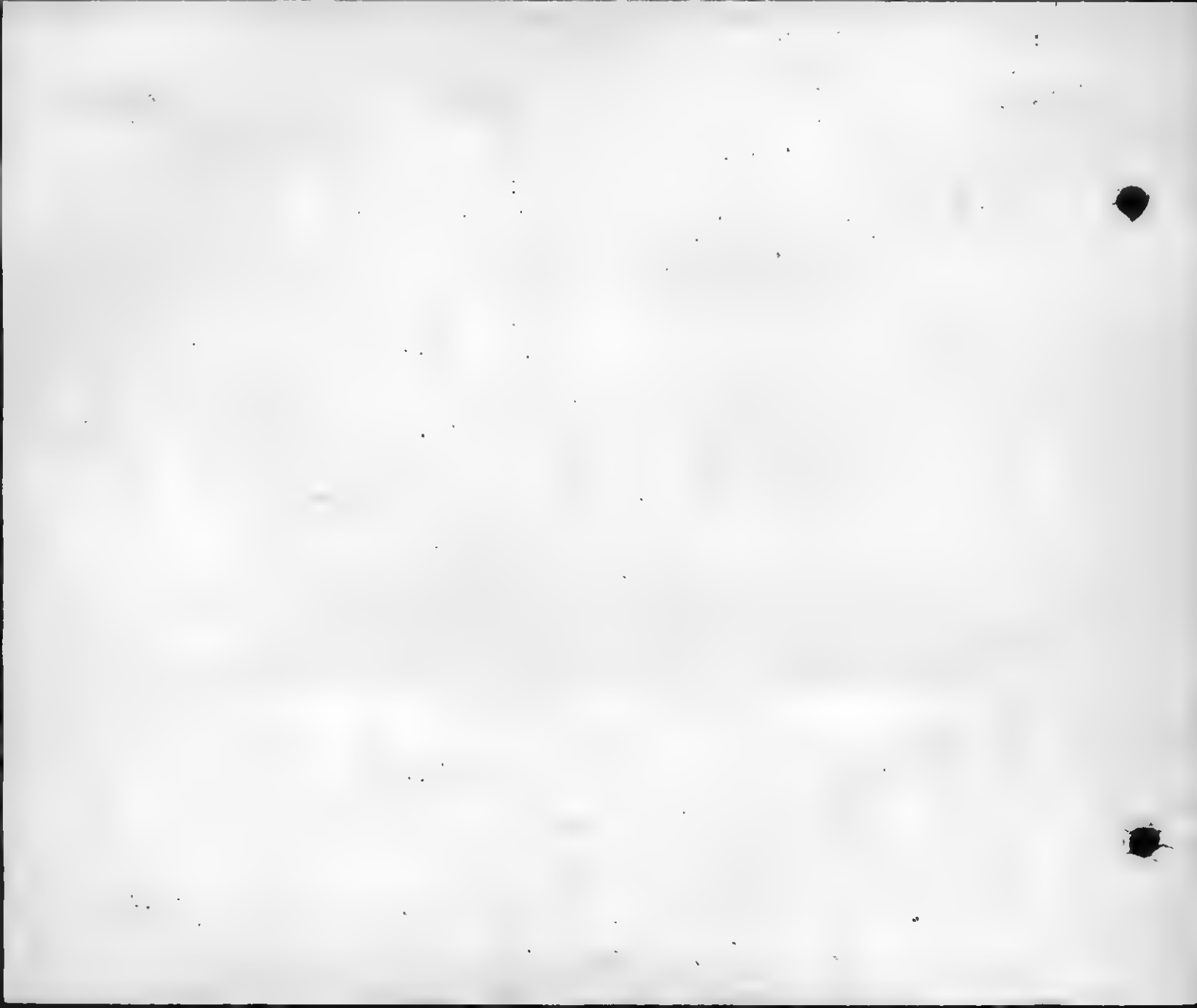
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

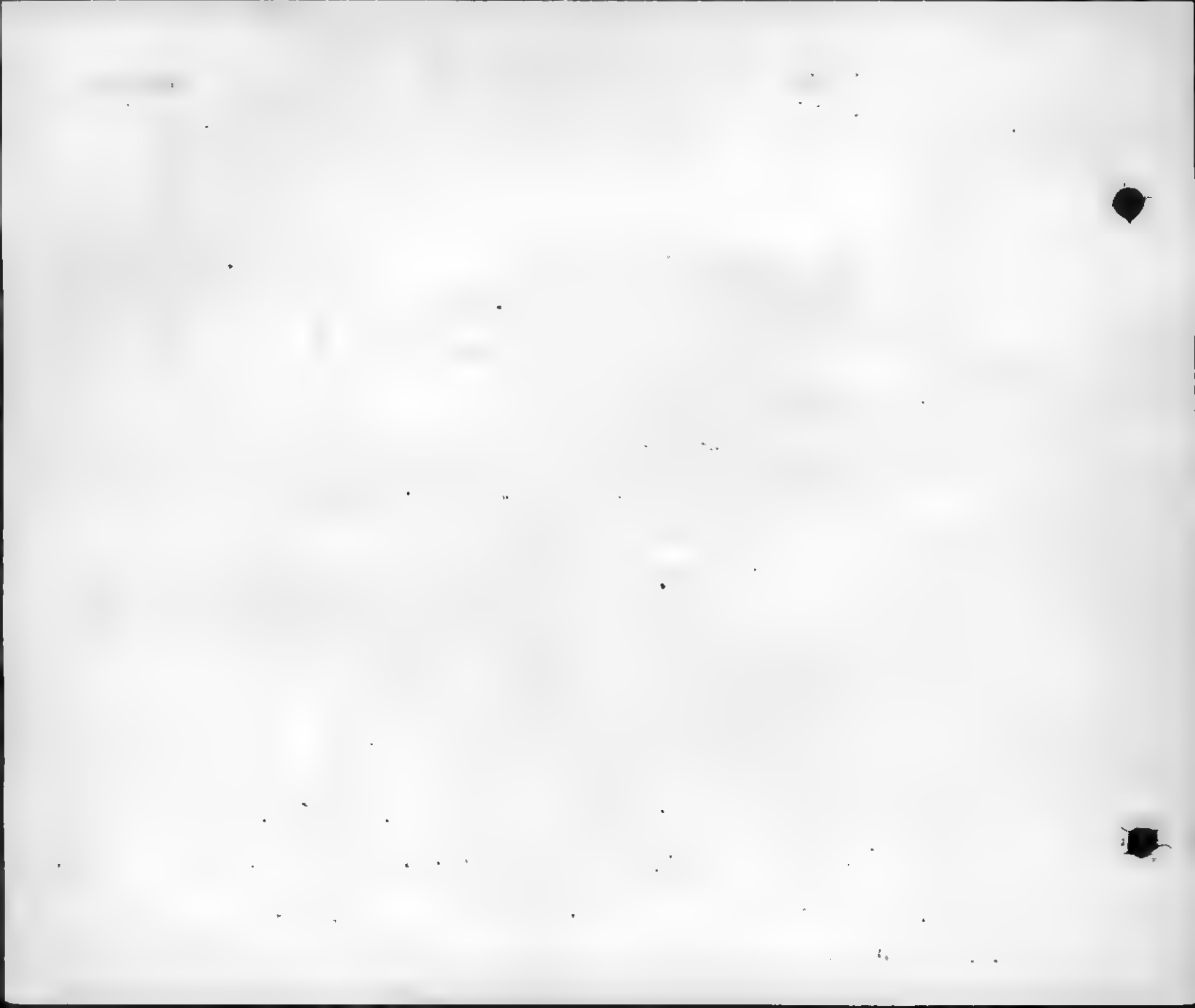
Items 11 & 12 Film G-95 9/18/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite c. LENGTH OF STAY IN lb Granite d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bunker Hill		2. USUAL RESIDENCE (Where deceased lived. If institution, Reside. in inst. or in institution) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite d. STREET ADDRESS Bunker Hill e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle JOHNSON Last WALKER		4. DATE OF DEATH Month Sept. Day 7 Year 1961 19	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1904
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 7 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Unknown Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Johnson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-24-2521	
17. INFORMANT Katie Hodge, Granite, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterial hypertension DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr ? ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1928 to 9/7/61 , that I last saw the deceased alive on 9/5/61 , and that death occurred at Md , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pandallstown Md DATE SIGNED ACTUAL SIGNATURE Wm E. Martin M.D. Pandallstown Md PHYSICIAN'S NAME (Type) Wm E. MARTIN PANDALLSTOWN Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-61	
22c. NAME OF CEMETERY OR CREMATORY Cherry Hill		22d. LOCATION (City, town, or county) (State) Granite, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR SEP 11 '61 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinsch			

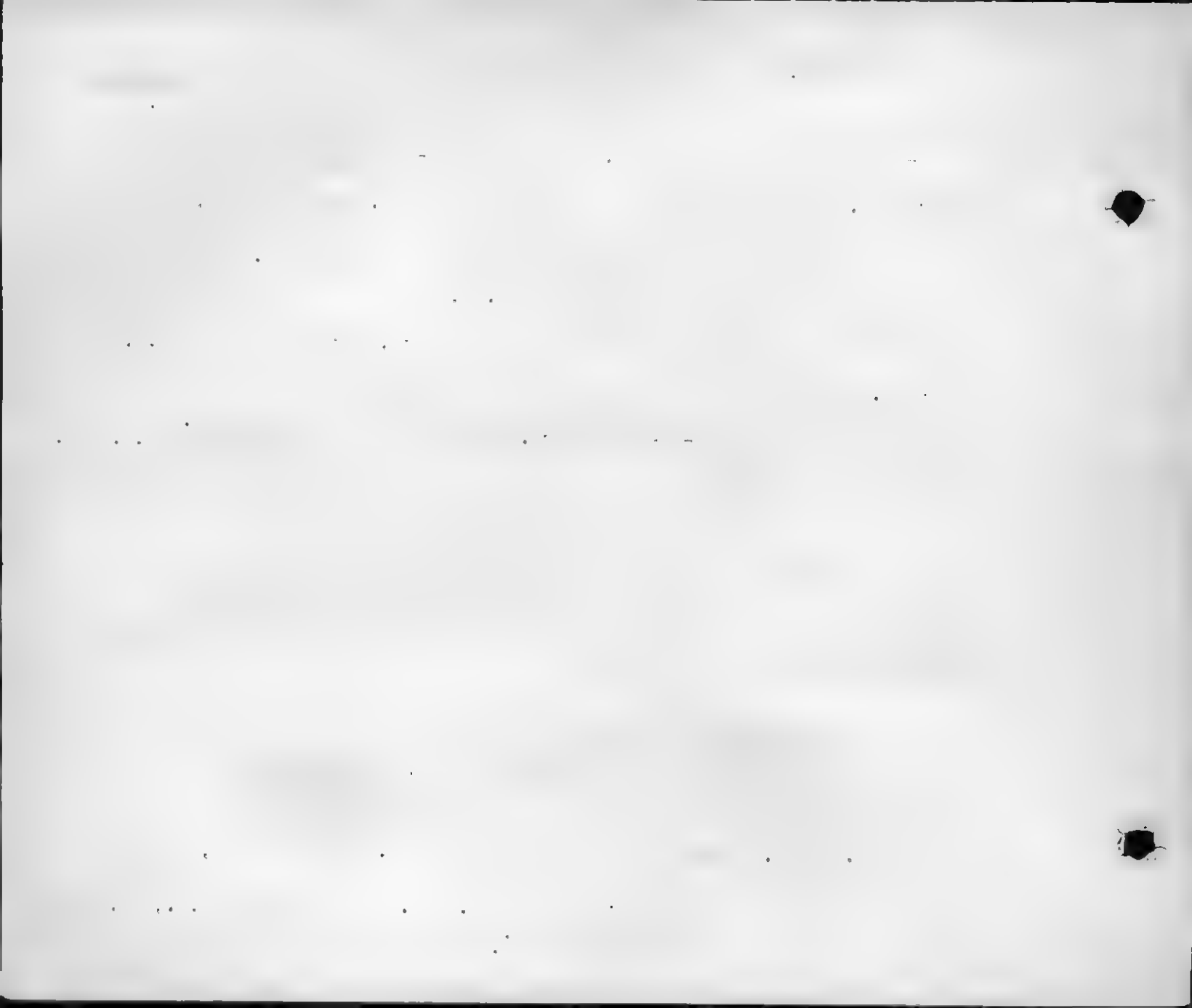
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10021 CERTIFICATE OF DEATH 10014

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Holbrook		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Holbrook	
c. LENGTH OF STAY IN 1b 17 yrs.		d. STREET ADDRESS Liberty Rd. Randallstown P.O.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Liberty Rd. Randallstown P.O.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Roland Walsh		4. DATE OF DEATH Month Day Year Sept. 16 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1892
9. AGE (in years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Walsh		14. MOTHER'S MAIDEN NAME Mary Jane Wills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-05-1443	
17. INFORMANT Mrs. Bernice G. Walsh		Address Liberty Rd. Holbrook Randallstown, P.O., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Puncture of Aneurysm of Abdominal Aorta 451X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 20 min			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to 9/16/1961 , that (I) (we) last saw the deceased alive on 9/16/1961 and that death occurred on 9/16/1961 , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Wm. E. Martin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Wm. E. Martin		22d. ADDRESS Liberty Rd. Harrisonville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-61	
23c. NAME OF CEMETERY OR CREMATORY Hereford Baptist Ch. Cem.		23d. LOCATION (City, town, or county) (State) Hereford, Balto. C., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Byers		25a. REC'D BY REGISTRAR DATE SEP 21 '61	
25b. REGISTRAR'S SIGNATURE Charles S. House			

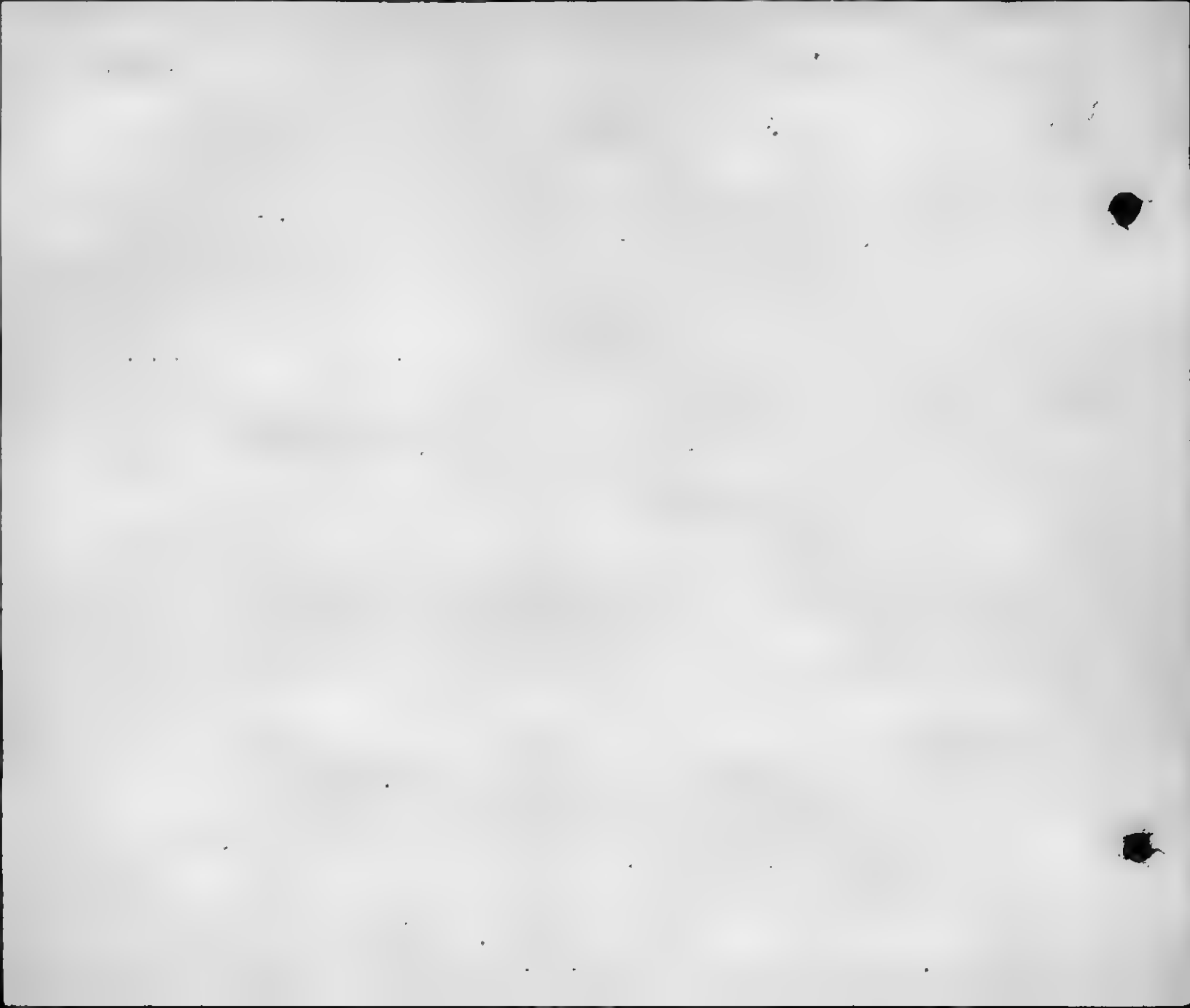


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
10022		10015	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY	Baltimore	a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Fort Howard	b. COUNTY	Baltimore
c. LENGTH OF STAY IN 1b	2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	316 N. Poppleton St. - 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Veterans Administration Hospital	d. STREET ADDRESS	WATERS
3. NAME OF DECEASED (Type or print)	S.A. ARTHUR	4. DATE OF DEATH	September 16 1961
5. SEX	Male	6. COLOR OR RACE	Negro
7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH	January 25, 1891
9. AGE (In years, last birthday)	70 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Truck Driver
11. BIRTHPLACE (Country & State, or foreign country)	Frederick, Maryland	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
13. FATHER'S NAME	Newton Waters	14. MOTHER'S MAIDEN NAME	Sarah Ellicott
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	Yes	16. SOCIAL SECURITY NO.	216-12-3931
17. INFORMANT	Clinical Records, VA Hospital	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	PULMONARY EMBOLUS, RIGHT
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner.)	ATELECTASIS, CHRONIC, LEFT
21. I certify that (this hospital) attended the deceased from Sept. 14, 1961, to Sept. 16, 1961, that (I) (we) last saw the deceased alive on Sept. 16, 1961, and that death occurred at 1:10 P.M. from the causes and on the date stated above.		22. SIGNATURE	Donald W. Stewart
23. PHYSICIAN'S NAME (Type)	DONALD W. STEWART, M.D.	24. ADDRESS	VAH Baltimore 18, Md.
25. BURIAL, CREMATION, REMOVAL (Specify)	Burial	26. DATE THEREOF	9-19-61
27. NAME OF CEMETERY OR CREMATORY	Baltimore National Cemetery	28. LOCATION (City, town or county)	Baltimore Maryland
29. FUNERAL DIRECTOR'S SIGNATURE	Elroy O. Wilson	30. REC'D BY REGISTRAR	SEP 27 '61
31. REGISTRAR'S SIGNATURE	Arthur L. Hume	32. DATE	SEP 27 '61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

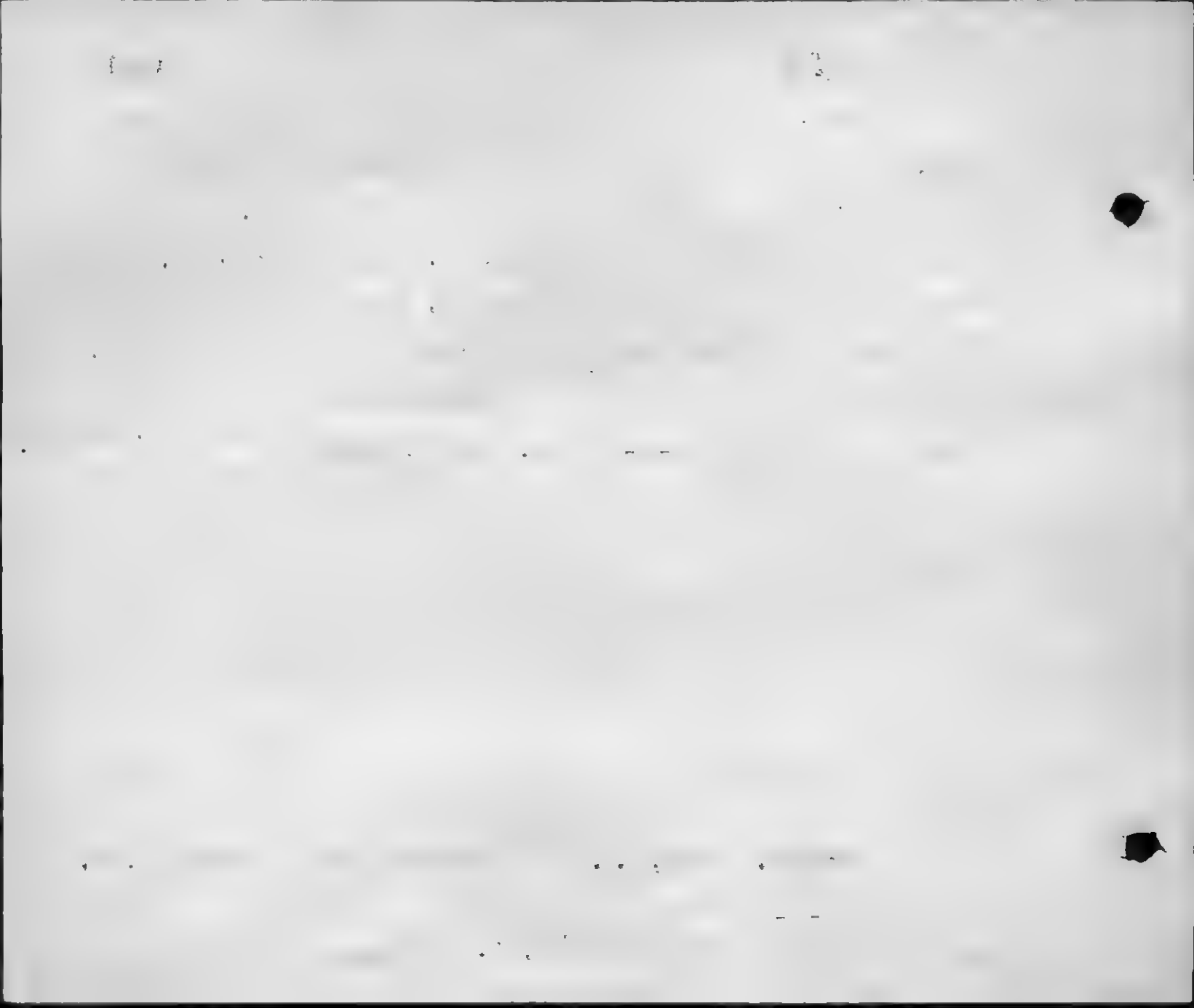
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10023

CERTIFICATE OF DEATH

10016

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY (in days) <u>52 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1305 Malbay Drive</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> Baltimore b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> Baltimore 15 d. STREET ADDRESS <u>5631 Reisterstown Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Russell</u> First <u>Wedge, Sr.</u> Middle <u>Wedge, Sr.</u> Last		4. DATE OF DEATH <u>Sept. 22,</u> 19 <u>61</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 18, 1884</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Money Room</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Par Mutuals Race Track</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William Wedge</u> 14. MOTHER'S MAIDEN NAME <u>Florence McClure</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>213-10-7379</u> 17. INFORMANT <u>Mr. Robert R. Wedge</u> Address <u>1305 Malbay Dr. Lutherville Md.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> (b) <u>arteriosclerosis</u> (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that (1) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>61</u> , to <u>9/22</u> , 19 <u>61</u> , that (1) (we) last saw the deceased alive on <u>9/22</u> , 19 <u>61</u> , and that death occurred at <u>11:50 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>George T. Gilmore</u> M.D. 22b. DATE SIGNED <u>9/22</u> 22c. PHYSICIAN'S NAME (Type) <u>George T. Gilmore, M.D.</u> 22d. ADDRESS <u>Lanham Building Lutherville, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-26-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> 23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u> 25a. REC'D BY REGISTRAR <u>SEP 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>									



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10024 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10017

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b <u>2½ mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3104 Brightwood Ave.</u> d. STREET ADDRESS <u>3104 Brightwood Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MATILDA E. WEISS</u>				4. DATE OF DEATH <u>September 1 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>				8. DATE OF BIRTH <u>Jan. 15, 1898</u>		9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Keaton Rubber Co. Austria</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Eichner</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Ziegler</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>139-20-7892</u>		17. INFORMANT <u>Mr. Sheldon G. Weiss-3104 Brightwood Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Ca. Rt. Breast with Metastasis</u> (c) <u>Ca. Left Breast with Mastectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Osteoarthritis, Fract. neck Rt. Femur</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3½ yrs.</u> <u>3 yrs.</u> <u>6 mos.</u> <u>3½ yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell out of bed at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>6-7 a.m. Feb. 8 1961</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Newark</u> (County) <u>N.J.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>D.D. Caples</u>				M.D. <u>D. D. Caples, M. D., 6 Hanover Rd. Reisterstown, Md.</u>		DATE SIGNED <u>9-1-61</u>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D., 6 Hanover Rd. Reisterstown, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Removal</u>				22b. DATE THEREOF <u>9-1-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth David Corp.</u>		22d. LOCATION (City, town, or country) <u>Union County, New Jersey</u> (State)	
23. FUNERAL DIRECTOR <u>Sol. Levinson & Bros. Inc., 6010 Reist. Road</u>				ADDRESS <u>6010 Reist. Road</u>		24a. REC'D BY REGISTRAR <u>5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M
I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10025

10018

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1120 Arran Road</u>		d. STREET ADDRESS <u>1120 Arran Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Louisa D. Wells</u>		4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct, 6, 1883</u>
9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>77</u> yrs. Months <u>7</u> Days <u>7</u> Hours <u>7</u> M.n. <u>7</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ferdinand A. Annreich</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Johnston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Mrs. Ida Scott 1120 Arran Rd. #4</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Terminal myocardial infarction</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>myocardial insufficiency & Angina Pectoris</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u> cause last.				DUE TO <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) <u>Leonard H. Flax</u> attended the deceased from <u>9/4</u> to <u>9/5</u> , 19 <u>61</u> , that (I) <u>was</u> last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:15 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Leonard H. Flax, M.D.</u>		22b. DATE SIGNED <u>9/5/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Leonard H. Flax, M.D.</u>	
22d. ADDRESS <u>1202 St. Paul St. #2</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem</u>	23d. LOCATION (City, town or county)	(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanel</u>	

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT.

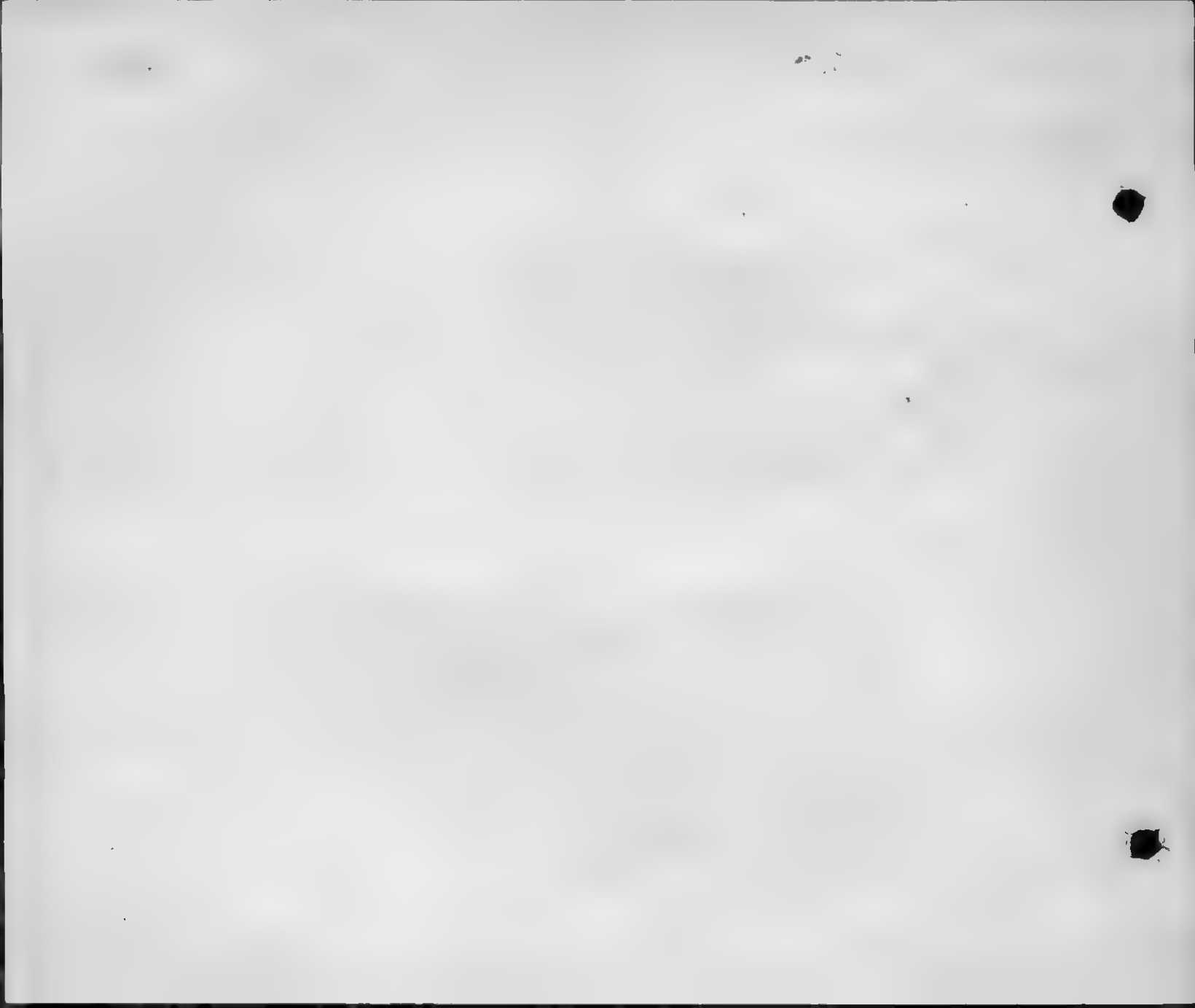
(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>10026</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>10019</div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>BALTO</div> <div>MARYLAND</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>MD</div> <div>b. COUNTY</div> <div>BALTO</div> </div> </div>																							
<div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>DUNDACK</div> </div>				<div> <div>c. LENGTH OF STAY IN 1b</div> <div>35 YRS</div> </div>				<div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>DUNDACK</div> </div>				<div> <div>d. STREET ADDRESS</div> <div>1807 SNYDER AVE</div> </div>											
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>1807 SNYDER AVE</div> </div>				<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>																			
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>JOSEPH ALEXANDER WHEELKLY</div> </div>				<div> <div>4. DATE OF DEATH</div> <div>SEPT. 9, 1961</div> </div>																			
<div> <div>5. SEX</div> <div>MALE</div> </div>		<div> <div>6. COLOR OR RACE</div> <div>WHITE</div> </div>		<div> <div>7. MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> </div>		<div> <div>8. DATE OF BIRTH</div> <div>APR. 12, 1886</div> </div>		<div> <div>9. AGE (in years last birthday)</div> <div>75 yrs</div> </div>		<div> <div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div> </div>		<div> <div>IF UNDER 24 HRS.</div> <div>Hours Min.</div> </div>											
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>ENGINEER</div> </div>				<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>RAILROAD</div> </div>				<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>MD</div> </div>				<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>											
<div> <div>13. FATHER'S NAME</div> <div>ALEXANDER WHEELKLY</div> </div>				<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>LOUISE WILSON</div> </div>																			
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>NO</div> </div>				<div> <div>16. SOCIAL SECURITY NO.</div> <div>705-05-5144</div> </div>				<div> <div>17. INFORMANT</div> <div>WELLIE WINEHOLT WHEELKLY</div> </div>				<div> <div>Address</div> <div></div> </div>											
<div> <div>18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>420.1 DUE TO</div> <div>Coronary Occlusion</div> <div>A-S-C-V-Disease</div> <div>Conditions, if any, which gave rise to immediate cause (b)</div> <div>(c)</div> <div>DUE TO</div> <div>cause last.</div> </div>												<div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div></div> </div>											
<div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</div> <div></div> </div>																							
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div></div> </div>				<div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>No one</div> </div>																			
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div> </div>				<div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div>				<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div></div> </div>				<div> <div>20f. (City or town)</div> <div></div> </div>				<div> <div>(County)</div> <div></div> </div>				<div> <div>(State)</div> <div></div> </div>			
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div> <div>ACTUAL SIGNATURE</div> <div>M.B. Davis MD</div> <div>EXAMINER'S NAME (Type)</div> </div> </div>																							
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> </div>				<div> <div>22b. DATE THEREOF</div> <div>9/13/61</div> </div>				<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>MORELAND MEM.</div> </div>				<div> <div>22d. LOCATION (City, town, or country)</div> <div>BALTO. MD</div> </div>				<div> <div>(State)</div> <div></div> </div>							
<div> <div>23. FUNERAL DIRECTOR</div> <div>Walter Burke Rodley, Hurdock</div> </div>												<div> <div>24a. REC'D BY REGISTRAR</div> <div>SEP 13 '61</div> </div>				<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Hanna</div> </div>							

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

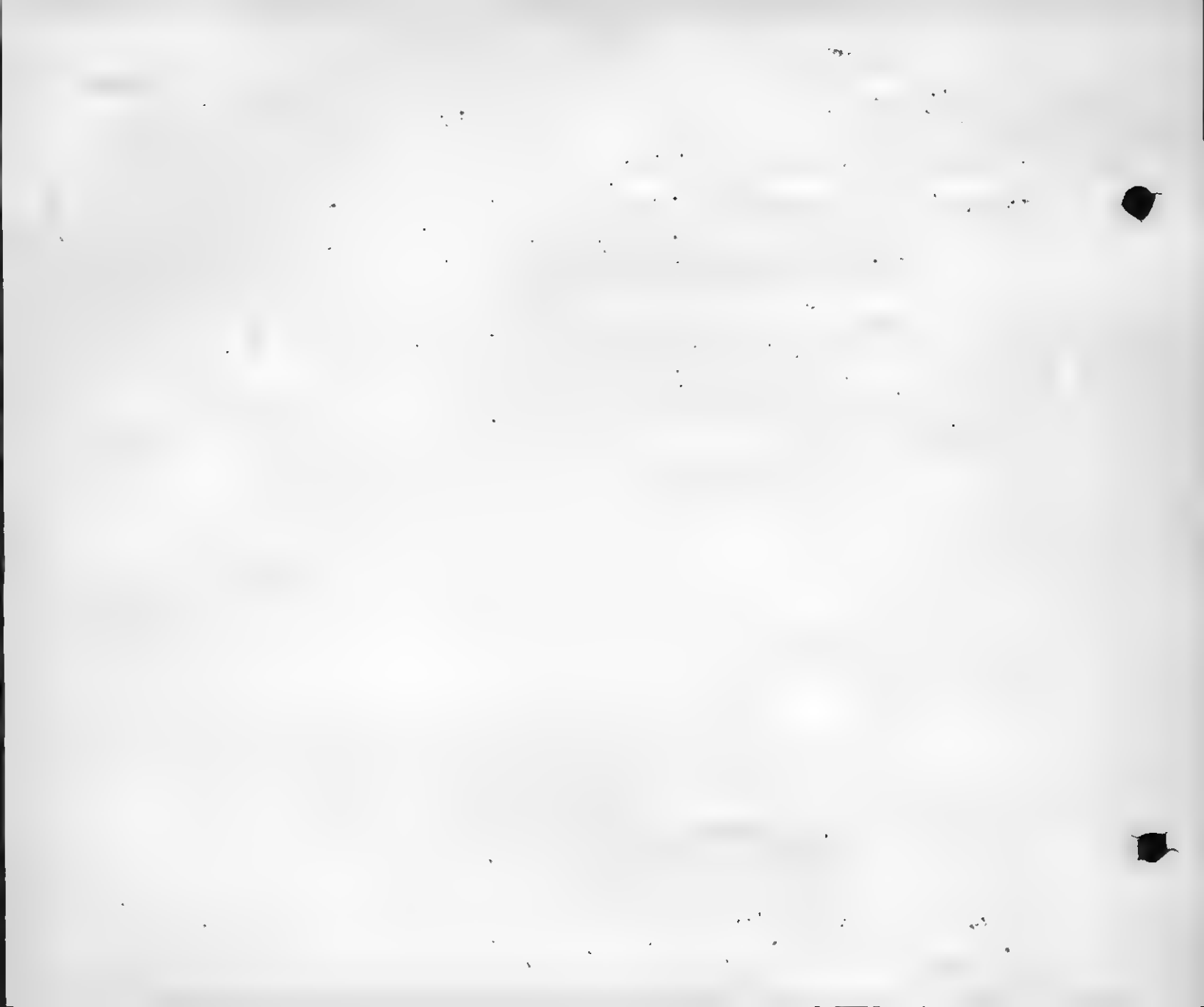
Reg. Dist. No.

10027

10020

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION <u>Robb Nursing Home 4105 Essex Rd.</u>		e. STREET ADDRESS <u>1745 Park Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Zelona M. Whitcraft</u>		4. DATE OF DEATH <u>Sept. 25, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Whitcraft</u>		14. MOTHER'S MAIDEN NAME <u>Lida Conway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>RA Whitcraft, Parkton, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 42000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of tibia and fibula - compound</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fall from ladder</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>June 1961</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Balto. Md</u>	
21. I certify that I attended the deceased from <u>June 19, 1961</u> to <u>Sept 25, 1961</u> , that I last saw the deceased alive on <u>Sept 25, 1961</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Riviera Cpts Balto. 17</u> DATE SIGNED <u>9/25/61</u>			
ACTUAL SIGNATURE <u>Heber J. Gundersen</u> M.D.		PHYSICIAN'S NAME (Type) <u>A</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 28, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stewartstown Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24. REC'D BY REGISTRAR DATE <u>SEP 29 '61</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9 60

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 & 9 Film G-95

10021

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Catonville

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Md. State Forest Reserve

3 NAME OF DECEASED
(Type or print)

First

CHARLES

Middle

H.

Last

WHITE

5. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

8/15/99

9. AGE (In years last birthday)

62 3/4

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Refinery & Smelting

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-01-5063

17. INFORMANT

Genevieve

Address

713 W. Lafayette Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)

INTERVAL BETWEEN ONSET AND DEATH

Partial

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part-II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Howard Shaub, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

DATE SIGNED

9/5/61

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9/9/61

22c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

22d. LOCATION (City, town, or country)

Baltimore

Md.

23. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre Street

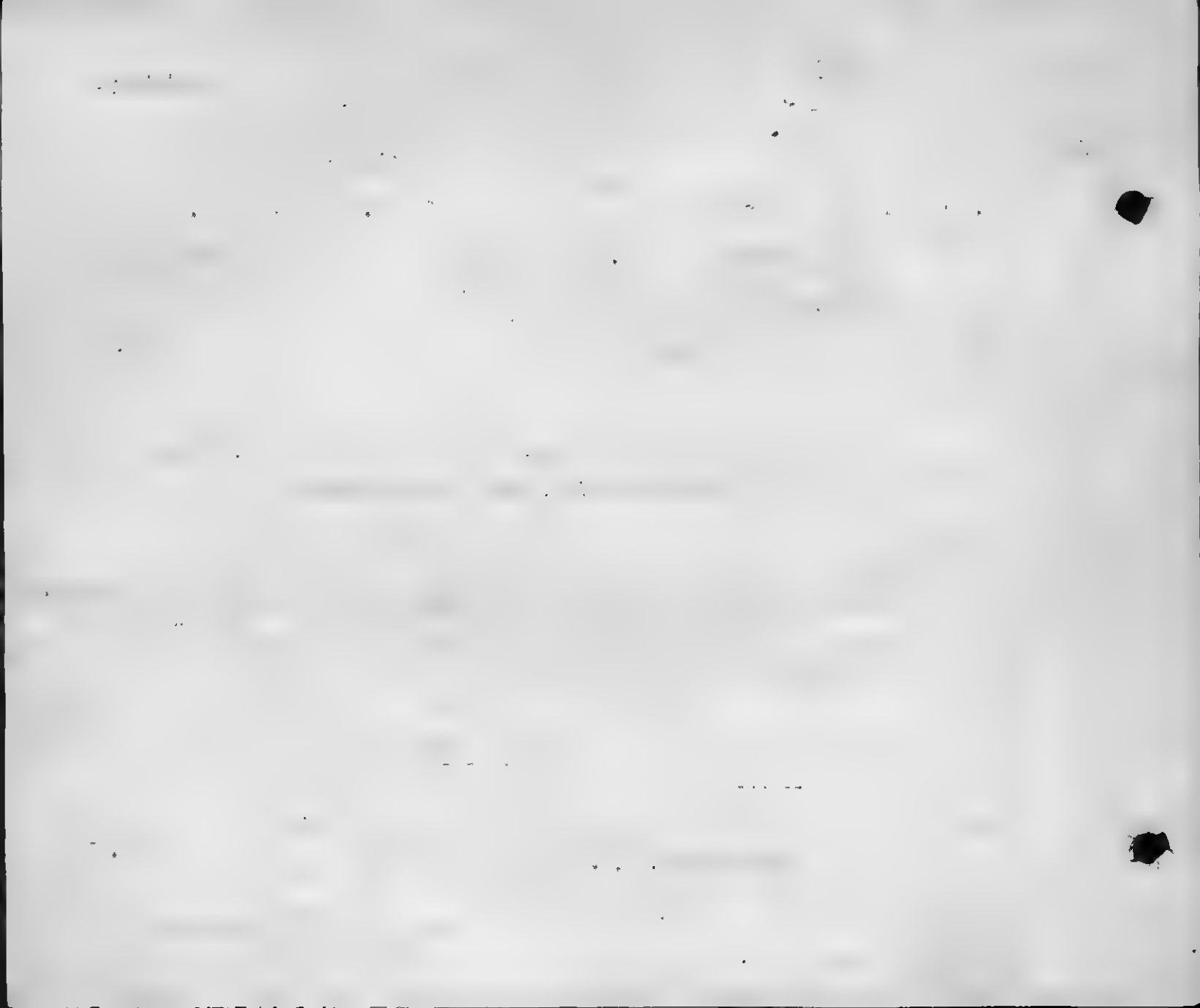
ADDRESS

24a. REC'D BY REGISTRAR

DATE SEP 13 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kins



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10028

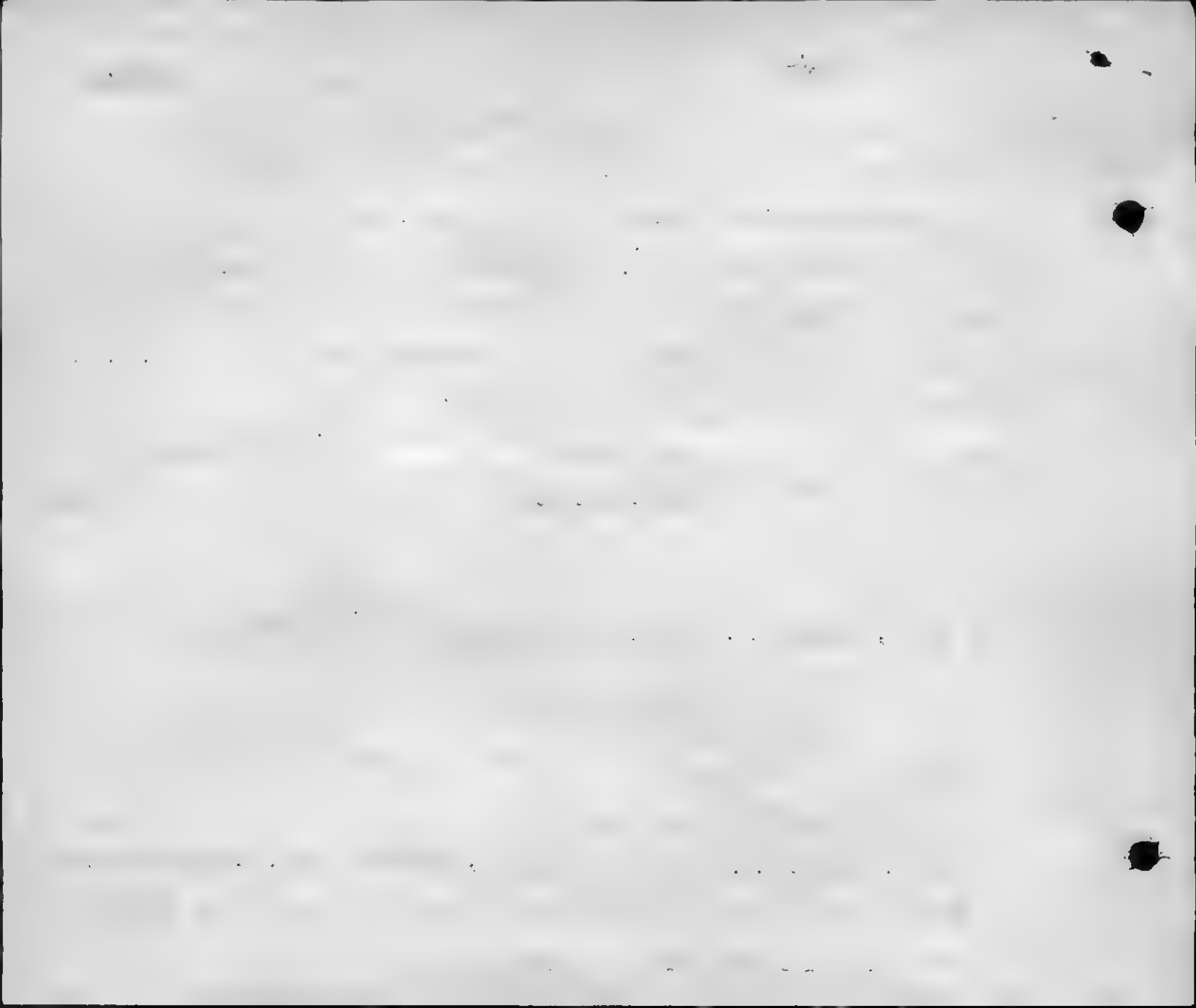
10022

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 14 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 d. STREET ADDRESS 79 Wise Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RAY S. WILKERSON (Served as RAY S. WILKERSON)		4. DATE OF DEATH September 6 1961	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/31/95		9. AGE (In years last birthday) 66 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitter 10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Wilkerson 14. MOTHER'S MAIDEN NAME Martha Forsythe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 216-10-4048 17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT LUNG DUE TO (b) 165X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 165X PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA, OBSTRUCTIVE. Operation 1/27/61 Wedge biopsy, prescalene node 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT LUNG DUE TO (b) 165X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 165X PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA, OBSTRUCTIVE. Operation 1/27/61 Wedge biopsy, prescalene node 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (th's hospital) attended the deceased from Aug. 23 1961 to Sept. 6 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 6 1961 , and that death occurred at 6:50 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Crahan</i> 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22b. DATE SIGNED 9/6/61 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-8-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery 23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.		25a. REC'D BY REGISTRAR SEP 8 '61 25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) 212 Church Lane, Pikesville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hannah Frances Wimsett		4. DATE OF DEATH Month Sept. Day 4, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1877
9. AGE (in years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster	11. BIRTHPLACE (State or foreign country) Stevenson, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Menery Wimsett, Sr.	
14. MOTHER'S MAIDEN NAME Mary Mertin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Margaret E. Wimsett, Pikesville 8, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - chronic 143X DUE TO decompensating Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 year year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-42 to 9-4-61 , that (I) (we) last saw the deceased alive on 9-27-1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 9-4-61	
22c. PHYSICIAN'S NAME (Type) James G. Saffell MD		22d. ADDRESS Reisters town, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 7, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Charles Church	23d. LOCATION (City, town, or county) (State) Pikesville 8, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell		25a. REC'D BY REGISTRAR SEP 11 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Rimes			

FOR
HEAD

Day is necessary,
al director. Page
at for your files

TO DEF. / MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a
please execute the certificate, writing the word "pending" in pencil in item 18. Give 2, and 3 to it
4 should be forwarded to the Chief Medical Examiner's Office along with

YS. A15.
SM 7/5

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10024

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

ORCHARD INN, Joppa Rd.

3. NAME OF DECEASED (Type or print)

GEORGE BERNARD YOUNG

5. SEX

MALE

6. COLOR OR RACE

W.

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Oct 21 1906

9. AGE (in years last birthday)

54

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not listed)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

ORCHARD INN

11. BIRTHPLACE (State of foreign country)

WASH D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

ARTHUR V. YOUNG

14. MOTHER'S MAIDEN NAME

MARGARET GILCHRIST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. M. J. Young 3710 ELKADER RD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Coronary Occlusion
Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

Sudden
6 Mins.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles F. O'Donnell

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

DATE SIGNED

9/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

9/25/61

22c. NAME OF CEMETERY OR CREMATORY

CATHEDRAL CEM

22d. LOCATION (City, town, or county)

BALTO

23. FUNERAL DIRECTOR

NIEDEFFELD & SON 501 E. 22ND ST

ADDRESS

24a. REC'D BY REGISTRAR

SEP 26 '61

24b. REGISTRAR'S SIGNATURE

C. ... S. Frank

MEDICAL CERTIFICATION

1 STATE II DEPT. M

Form PMS-Page 5 may be retained as a burial-transit permit. Pages 1 and 2 with the State Board of Health or in designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

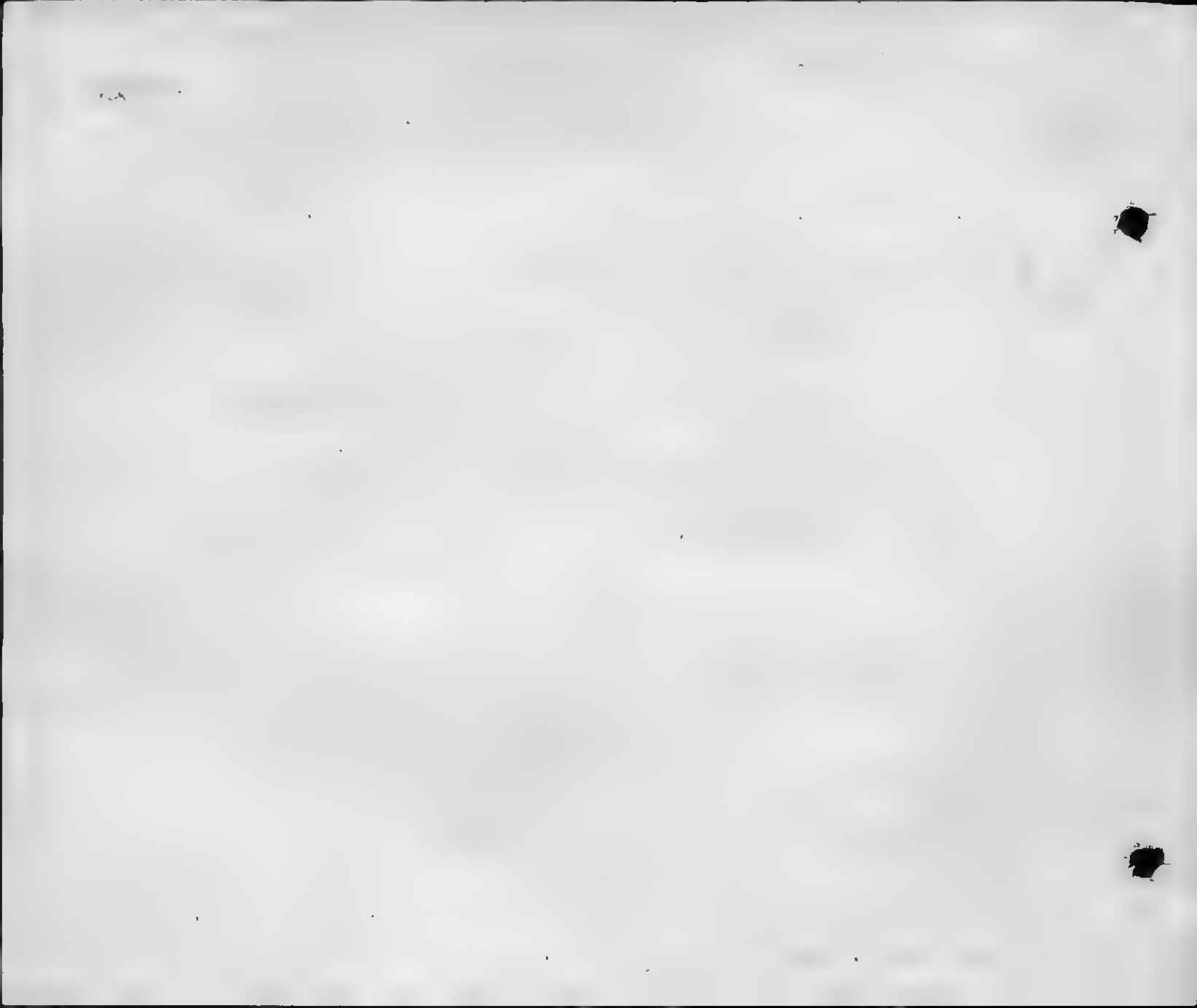
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10032

10025

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Rosedale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1219 63rd St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; if not, give address where deceased lived) e. STATE <u>Md.</u> f. COUNTY <u>Baltimore</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rosedale</u> h. STREET ADDRESS <u>1219 63rd St.</u>					
3. NAME OF DECEASED (Type or print) <u>Maru</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-13-1096</u> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years) IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday Months Days Hours Min. <u>65</u> yrs. <u>Sept.</u> <u>30</u> <u>19</u> <u>67</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 11. KIND OF BUSINESS OR INDUSTRY <u>Greece</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Andrew Pyros</u> 14. MOTHER'S MAIDEN NAME <u>Arhontoula Vassilaros</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>11rs James Mastrogeorge</u> 17. INFORMANT <u>same</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple pulmonary infarcts</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> 19 <u>67</u> to <u>Sept 30</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 30</u> 19 <u>67</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>John B. Orth</u> 22c. PHYSICIAN'S NAME (Type) <u>John B. Orth</u> 22b. DATE SIGNED <u>Sept 30</u> 19 <u>67</u> 22d. ADDRESS <u>8019 Philad. Rd. Baltimore, Md.</u> 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>10-2-1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Greek Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u> 25a. REC'D BY REGISTRAR <u>OCT 3 '67</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Ruck</u>								26. DATE OF DEATH <u>Sept 30</u> 19 <u>67</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10033

CERTIFICATE OF DEATH

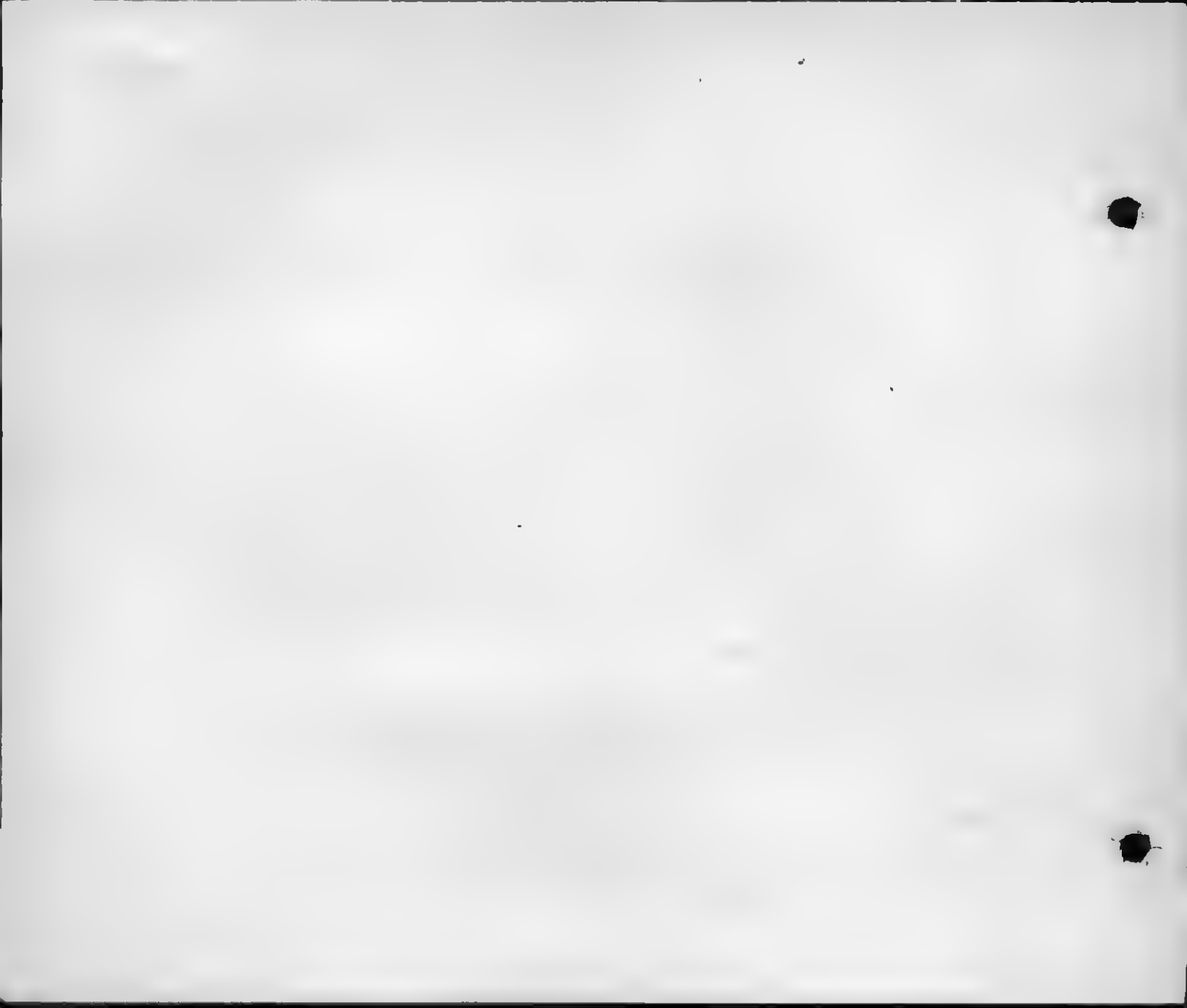
Reg. Dist. 10026

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hillside Ave</i>		e. STREET ADDRESS <i>1 Hillside Ave</i>	
3 NAME OF DECEASED (Type or print) <i>Walter Mason Zembower</i>		4. DATE OF DEATH <i>September 18 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 18, 1892</i>
9. AGE (In years last birthday) <i>69</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Quarry</i>	
11. BIRTHPLACE (State or foreign country) <i>Everett Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Josiah Zembower</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Jane Mortimer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>...</i>	
17. INFORMANT <i>Wife</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <i>Arteriosclerotic cardiac vascular disease</i> DUE TO <i>2 Coronary Insufficiency</i> (c)		<i>7-8 minutes</i> <i>over 5-4-15</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 19 <i>61</i> , to <i>Sept 61</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>14 Sept</i> , 19 <i>61</i> , and that death occurred at <i>5:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		DATE SIGNED <i>18 Sept 1961</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>SEPT. 20 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Cockeysville, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns' Sons, Towson, Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 28 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneiss</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

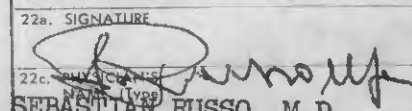

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution, residence prior to admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						c. LENGTH OF STAY IN 1b 11 Days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 1610 Popland Street					
3. NAME OF DECEASED (Type or print) FREDERICK C. ZIEMER						4. DATE OF DEATH Month Day Year September 26 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1897		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY Fruit Company				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Ziemer						14. MOTHER'S MAIDEN NAME Elizabeth Hohman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I						16. SOCIAL SECURITY NO. 705-10-6485					
17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL HEMORRHAGE 5811 DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) LAENNEC'S CIRRHOSIS (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 15 1961 to September 26 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 26 1961 and that death occurred at 10:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE  SEBASTIAN RUSSO, M.D.						22b. DATE SIGNED 9/26/61					
22c. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-29-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) Baltimore 28, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski, 4200 Pennington Ave. Balto. Md.						25a. REC'D BY REGISTRAR DATE SEP 27 '61					
						25b. REGISTRAR'S SIGNATURE 					

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15M 9/60

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(M)

Western Administration Building
1000 Broadway
New York, N.Y. 10003
Telephone: (212) 512-1000
Teletype: (212) 512-1000
Cable: WADN
Fax: (212) 512-1000
Internet: www.wadn.org
E-mail: info@wadn.org

1000 Broadway
New York, N.Y. 10003
Telephone: (212) 512-1000
Teletype: (212) 512-1000
Cable: WADN
Fax: (212) 512-1000
Internet: www.wadn.org
E-mail: info@wadn.org

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10035					10028									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY Baltimore					a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					b. COUNTY Prince George									
c. LENGTH OF STAY IN 1b 2yr10mth					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Maryland									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 4500 Yates Road									
3. NAME OF DECEASED (Type or print) Margaret Zoelle					4. DATE OF DEATH SEPT 28, 1961									
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1881		9. AGE (In years last birthday) 79 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown					16. SOCIAL SECURITY NO. unknown					17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscl. Cardiovasc. Disease 422-1 DUE TO Arteriosclerosis, general, severe Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from Nov. 26, 1958 to 9/28, 1961, that (I) (we) last saw the deceased alive on 9/28, 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Stella Wachslar						22b. DATE SIGNED 9/28/61			22c. PHYSICIAN'S NAME (Type) STELLA WACHSLER					
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 2, 1961				23b. DATE THEREOF Oct 2, 1961				23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery						
23d. LOCATION (City, town, or county) Cleveland, Ohio				23e. REC'D BY REGISTRAR DATE OCT 2 '61				23f. REGISTRAR'S SIGNATURE Arthur S. Kneale						

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